Methods, Standards, and Principles for Establishing
Medicaid Payment Rates for Long-Term Care Facilities

5.101 Definitions

For the purposes of this rule, the term:

Accrual Basis of Accounting means an accounting system in which revenues are reported in the period in which they are earned, regardless of when they are collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

AICPA means the American Institute of Certified Public Accountants.

Allowable Costs or Expenses means costs or expenses that are recognized as reasonable and related to resident care in accordance with these rules.

Base Year means a calendar year for which the allowable costs are the basis for the case-mix prospective per diem rate.

Case-Mix Weight means a relative evaluation of the nursing resources used in the care of a given class of residents.

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

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

Common Control means 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 means 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 means a Licensed Nurse Aide (LNA) with specialized training in person-centered dementia care**.**

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

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

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

Director means the Director of Rate Setting.

Division means the Division of Rate Setting, Department of Vermont Health Access, Agency of Human Services.

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

Facility or nursing facility means a nursing home facility licensed and certified for participation in the Medicaid Program by the State of Vermont.

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

FASB means Financial Accounting Standards Board.

Final Order of the Division means 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 means a facility that is not hospital-affiliated.

Funded Depreciation means 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 include benefits such as 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) means 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, and other pronouncements of the AICPA or FASB.

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

Health Care Cost Service means the 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 means a day for which the provider is paid to hold a bed open is counted as a resident day.

Hospital-affiliated facility means 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 means the added cost incurred in alternative choices.

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

Indirect Costs means 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 means 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 means a prospective Case-Mix rate paid to nursing facilities on a temporary basis.

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

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

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

New Health Care Project means 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 means the Omnibus Budget Reconciliation Act of 1987.

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

Paid feeding/dining assistants means 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 means the cost for one day of resident care.

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

Person-Centered Dementia Care means 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.

Prospective Case-Mix Reimbursement System means 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 means 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 means the State's fiscal year ending June 30.

Related organization or related party means 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 means 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 means 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 means funds and investment income earned from funds restricted for specific purposes by donors, excluding funds restricted or designated by an organization's governing body.

Secretary means the Secretary of the Agency of Human Services.

Special hospital-based nursing facility means 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 means Base Year resident days multiplied by the facility's average Case-Mix score for the base year.

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

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

5.101.1 General Provisions

5.101.1.1 Purpose

The purpose of these rules is to implement state and federal reimbursement policy with respect to nursing facilities providing services to Medicaid eligible persons. The methods, standards, and principles of rate setting established herein reflect the objectives set out in 33 V.S.A. §901 and balance the competing policy objectives of access, quality, cost containment and administrative feasibility. Rates set under this payment system are consistent with the efficiency, economy, and quality of care necessary to provide services in conformity with state and federal laws, regulations, quality and safety standards, and meet the requirements of 42 U.S.C. § 1396a(a)(13)(A).

5.101.1.2 Scope

These rules apply to all privately owned nursing facilities and state nursing facilities providing services to Medicaid residents. Long-term care services in swing-bed hospitals are reimbursed under different methods and standards. Swing-bed hospitals are reimbursed pursuant to 42 U.S.C. § 1396l(b)(1).

5.101.1.3 Authority

These rules are promulgated pursuant to 33 V.S.A. §§ 904(a) and 908(c) to meet the requirements of 33 V.S.A. Chapter 9, 42 U.S.C. §§ 1396a(a)(13)(A) and §1396a(a)(30).

5.101.1.4 General Description of the Rate Setting System

Vermont Medicaid shall employ a prospective case-mix payment system for nursing facilities in which the payment rate for services is set in advance of the actual provision of those services. A per diem rate is set for each facility based on the historic allowable costs of that facility. The costs are divided into certain designated cost categories, some of which are subject to limits. The basis for reimbursement within the Nursing Care cost category is a resident classification system that groups residents into classes according to their assessed conditions and the resources required to care for them. The costs in some categories are adjusted to reflect economic trends and conditions, and the payment rate for each facility is based on the per diem costs for each category.

5.101.1.5 Requirements for Participation in Medicaid Program

(a) Nursing facilities must satisfy all of the following prerequisites in order to participate in the Medicaid program:

(1) be licensed by the Agency, pursuant to 33 V.S.A. §7103(b),

(2) be certified by the Secretary of Health and Human Services pursuant to 42 C.F.R. Part 442, Subpart C, and

(3) have executed a Provider Agreement with the Agency, as required by 42 C.F.R. Part 442, Subpart B.

(b) To the extent economically and operationally feasible, providers are encouraged, but not required, to be certified for participation in the Medicare program, pursuant to 42 C.F.R. §488.3.

(c) Medicaid payments shall not be made to any facility that fails to meet all the requirements of Section 5.101.1.5(a).

5.101.1.6 Responsibilities of Owners

Owners must prudently manage and operate a residential health care program of adequate quality to meet its residents' needs. Regardless of the per diem rate set by the Division, or any other orders made by the Director, Commissioner, or Secretary under these rules the owner of a nursing facility must comply with the requirements and standards of the Agency of Human Services.

5.101.1.6 Duties of the Owner

The owner of a nursing facility, or a duly authorized representative shall:

(a) Comply with the provisions of these rules, the Nursing Facility Provider Manual, and all applicable state and federal laws and rules.

(b) Submit cost reports in accordance with the provisions of sections 5.101.3.2 and 5.101.3.3 of these rules and the Nursing Facility Provider Manual.

(c) Maintain adequate financial and statistical records and make them available at reasonable times for inspection by an authorized representative of the Division, the state, or the federal government.

(d) Assure that an annual audit is performed in conformance with Generally Accepted Auditing Standards (GAAS).

(e) Assure that the construction of buildings and the maintenance and operation of premises and programs comply with all applicable health and safety standards.

(f) Notwithstanding any other provision of these rules, any provider that fails to make a complete cost report filing within the time prescribed in section 5.101.3.3(a) or fails to file any other materials requested by the Division within the time prescribed shall receive no increase to its Medicaid rate until the first day of the calendar quarter after a complete cost report or the requested materials are filed, unless within an extension of time previously approved by the Division.

5.101.1.7 Powers and Duties of the Division and the Director

(a) The Division shall establish and certify to the Department of Vermont Health Access per diem rates for payment to providers of nursing facility services on behalf of residents eligible for assistance under Title XIX of the Social Security Act.

(b) The Division may request any nursing facility, related party, or similar individual or organization to file data, statistics, schedules, or information as the Division finds necessary to enable it to carry out its function.

(c) The Division may examine the books and accounts of any nursing facility, related parties, or similar individuals or organizations, subpoena witnesses and documents, administer oaths to witnesses and examine them on all matters over which the Division has jurisdiction.

(d) From time to time, the Director may issue notices of practices and procedures employed by the Division in carrying out its functions under these rules.

(e) The Director shall prescribe the forms required by these rules and instructions for their completion.

(f) The Director shall issue, amend, and enforce the Nursing Facility Manual.

(g) These rules and the Nursing Facility Manual apply regardless whether the Division's final per diem rates or final orders fail to enforce their provisions. If the Division's final per diem rates or final orders fail to enforce a provision of these rules or the Manual, that does not waive these rules or the Manual. The Division shall continue to have the right and the obligation to enforce these rules and the Manual.

5.101.1.8 Powers and Duties of the Department of Disabilities, Aging and Independent Living's Division of Licensing and Protection as Regards Reimbursement

(a) The Division of Licensing and Protection of the Department of Disabilities, Aging and Independent Living shall receive from providers resident assessments on forms it specifies. The Department of Disabilities, Aging and Independent Living shall process this information and shall periodically, but no less frequently than quarterly, provide the Division of Rate Setting with the average case-mix scores of each facility

based on Vermont Medicaid's chosen resident classification system. This score will be used in the quarterly determination of the Nursing Care portion of the rate.

(b) The management of the resident assessment process used in the determination of case-mix scores shall be the duty of the Division of Licensing and Protection of the Department of Disabilities, Aging and Independent Living. Any disagreements between the facility's assessment of a resident and the assessment of that same resident by the audit staff of Licensing and Protection shall be resolved with the Division of Licensing and Protection and shall not involve the Division of Rate Setting. As the final rates are prospective and adjusted on a quarterly basis to reflect the most current data, the Division of Rate Setting will not make retroactive rate adjustments as a result of audits or successfully appealed individual case-mix scores.

5.101.1.9 Computation of and Enlargement of Time, Filing and Service of Documents

(a) When computing time under these rules or the Nursing Facility Manual, the day of the act or event that begins a period of time shall not be included in that period. The last day of the period of time shall be included, unless it is a Saturday, Sunday, or state or federal legal holiday, in which case the period runs until the next business day..

(b) The addressee of any notice or document issued by the Division is rebuttably presumed to have received the notice or document three days after the date on the document.

(c) The Division may extend a period of time set in these rules with or without motion or notice for good cause. This section shall not apply to the time limits for appeals to the Vermont Supreme Court or Superior Court from Final Orders of the Division or Final Determinations of the Secretary, which are governed by the Vermont Rules of Appellate Procedure and the Vermont Rules of Civil Procedure respectively.

(d) Filing shall be deemed to have occurred when a document is received and date-stamped as received at the office of the Division or in the case of a document directed to be filed under this rule other than at the office of the Division, when it is received and stamped as received at the appropriate office. Filings with the Division may be made by telefacsimile (FAX), but the sender bears the risk of a communications failure from any cause. Filings with the Division may also be made electronically, but the sender bears the risk of a communications failure from any cause, including, but not limited to, filings blocked due to size. If a provider files a document by FAX or electronically, the provider need not file a hard copy of the document.

(e) The Division shall serve any document required to be served by this rule or the Nursing Facility Provider Manual in accordance with the Nursing Facility Provider Manual.

5.101.1.10 Representation in All Matters before the Division

A facility may be represented in any matter under this rule as described in the Nursing Facility Provider Manual.

5.101.1.11 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.

5.101.1.12 Effective Date

(a) These rules are effective from January 29, 1992 (as most recently amended July 1, 2024).

(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) If these rules or the Nursing Facility Provider Manual are amended while an administrative proceeding is pending, the Director or Secretary may apply the prior version of the rule or manual if applying the current version would work an injustice or substantial inconvenience.

5.101.2 Accounting Requirements

5.101.2.1 Accounting Principles

(a) All financial and statistical reports shall be prepared in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied, unless these rules or the Nursing Facility Provider Manual 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) Providers shall report on an accrual basis. Providers 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 reports

and the non-accrual fiscal accounts. The provider shall retain all such documentation for audit purposes.

5.101.2.2 Procurement Standards

Providers shall establish a code of standards to govern the performance of employees that procure goods and services in accordance with the Nursing Facility Provider Manual.

5.101.2.3 Cost Allocation Plans and Changes in Accounting Principles

Providers may reasonably allocate costs to the nursing facility from related entities, and may reasonably allocate costs from the nursing facility to related entities. The Division shall review cost allocations in accordance with the Nursing Facility Provider Manual. The Division reserves the right not to recognize changes in accounting principles or methods or bases of cost allocation that are unreasonable or are made for the purpose of, or having the likely effect of, increasing a facility's Medicaid payments.

5.101.2.4 Substance over Form

The substance of a transaction shall prevail over the form. Accordingly, the Division may adjust the cost effect of a transaction that circumvents the intention of these rules or the Nursing Facility Provider Manual.

5.101.2.5 Record Keeping and Retention of Records

(a) Each provider must maintain complete documentation of all records that substantiate the date the provider reports to the Division.

(b) Each provider must make all records described in subsection (a) of this section available to the Division of Rate Setting, the federal Department of Health and Human Services, and any authorized representatives of those agencies.

(c) Complete documentation means clear and compelling evidence of all of the financial transactions of the provider and affiliated entities, including but not limited to census data, ledgers, books, invoices, bank statements, canceled checks, payroll records, copies of governmental filings, time records, time cards, purchase requisitions, purchase orders, inventory records, basis of apportioning costs, matters of provider ownership and organization, resident service schedule and amounts of income received by service, or any other record which is necessary to provide the Director with the highest degree of confidence in the reliability of the claim for reimbursement. For purposes of this definition, affiliated entities shall extend to realty, management and other entities for which any reimbursement is directly or indirectly claimed whether or not they fall within the definition of related parties.

(d) The provider shall maintain all such records for at least six years from the date of filing, or the date upon which the fiscal and statistical records were to be filed,

whichever is the later. The Division shall keep all cost reports, supporting documentation submitted by the provider, correspondence, workpapers and other analyses supporting Summaries of Findings for six years. In the event of litigation or appeal involving rates established under these regulations, the provider and Division shall retain all records which are in any way related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.

(e) Pursuant to 33 V.S.A. § 908(a), all documents and other materials filed with the Division are public information, except for individually identifiable health information protected by law or the policies, practices, and procedures of the Agency of Human Services.

5.101.3 Financial Reporting

5.101.3.1 Repealed

5.101.3.2 Uniform Cost Reports

Each long-term care facility participating in the Vermont Medicaid program shall annually, or upon request, submit a uniform financial and statistical report (cost report) on forms prescribed by the Division and in accordance with the Nursing Facility Provider Manual.

5.101.3.3 Adequacy and Timeliness of Filing

(a) Providers shall file acceptable cost reports on or before the last day of the fifth month following the close of the period covered by the report, subject to the following exceptions:

(1) Hospital-based nursing homes shall file their Medicaid cost-reports within five days after filing their Medicare cost report for the same cost reporting period with CMS.

(2) If a hospital-based Medicaid nursing home's cost report is not filed on or before June 30 following the end of the facility's fiscal year, the Division may require the facility to provide certain data or to file a draft cost report.

(3) The Division may grant an extension to any facility's filing deadline, as described in the Nursing Facility Provider Manual.

(b) The Division may reject any filing which does not comply with these rules, the cost reporting instructions, or the Nursing Facility Provider Manual. If the Division rejects a cost report filing, the report shall be deemed not filed until the provider files an acceptable cost report that complies with these rules, the cost reporting instructions, and the Nursing Facility provider Manual.

(c) Repealed.

(d) Notwithstanding any other provision of these rules, any provider that fails to make a complete cost report filing within the time prescribed in section 5.101.3.3(a) or within an extension of time approved by the Divisions shall be subject to the provisions of section 5.101.1.7(f).

5.101.3.4 Review of Cost Reports by Division

(a) Uniform Desk Review

(1) The Division shall perform a uniform desk review on each cost report submitted.

(2) The uniform desk review is an analysis of the provider's cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded thereon, allowable costs and a summary of the results of the review for the purpose of either settling the cost report without an on-site audit or determining the extent to which an on-site audit verification is required.

(3) Uniform desk reviews shall be completed within an average of 18 months after receipt of an acceptable cost report filing, except in unusual situations, including but not limited to, delays in obtaining necessary information from a provider. Notwithstanding this subdivision, the Division shall have an additional six months to complete its review or audits of facilities' base year cost reports.

(4) Unless the Division schedules an on-site audit, it shall issue a written summary report of its findings and adjustments upon completion of the uniform desk review.

(b) On-site Audit

(1) The Division will perform on-site audits, as considered appropriate, of the provider's financial and statistical records and systems in accordance with the relevant provisions of the *Medicare Intermediary Manual - Audits-Reimbursement Program Administration*, CMS Publication 13-2 (CMS-13).

(2) The Division will base its selection of a facility for an on-site audit on factors such as length of time since last audit, changes in facility ownership, management, or organizational structure, evidence or official complaints of financial irregularities, questions raised in the uniform desk review, failure to file a timely cost report without a satisfactory explanation, and prior experience.

(3) The audit scope will be limited so as to avoid duplication of work performed by an independent public accountant, provided such work is adequate to meet the Division's audit requirements.

(4) Upon completion of an audit, the Division shall review its draft findings and adjustments with the provider and issue a written summary report of such findings.

5.101.3.5 Settlement of Cost Reports

(a) A cost report is settled if there is no request for reconsideration of the Division's findings or, if such request was made, the Division has issued a final order pursuant to section 5.101.15.3 of these rules.

(b) The Division may correct or reopen a determination or order regarding a cost report, even when it is final, in accordance with the process laid out in the Nursing Facility Provider Manual.

(c) Repealed.

(d) Repealed.

(e) Repealed.

(f) Repealed.

(g) Repealed.

5.101.4 Determination of Allowable Costs for Nursing Facilities

5.101.4.1 Provider Reimbursement Manual and GAAP

In determining the allowability or reasonableness of costs or treatment of any reimbursement issue not addressed in these rules or the Nursing Facility Provider Manual, the Division shall apply the appropriate provisions of the Medicare Provider Reimbursement Manual (CMS-15, formerly known as HCFA or HIM-15). If neither these rules nor the Nursing Facility Provider Manual nor CMS-15 specifically addresses a particular issue, the determination of allowability will be made in accordance with Generally Accepted Accounting Principles (GAAP). The Division reserves the right, consistent with applicable law, to determine the allowability and reasonableness of costs in any case not specifically covered in the sources referenced in this section.

5.101.4.2 General Cost Principles

For rate setting purposes, a cost must satisfy criteria, including, but not limited to, the following:

(a) The cost must be ordinary, reasonable, necessary, related to the care of residents, and actually incurred.

(b) The cost adheres to the prudent buyer principle.

(c) The cost is related to goods and/or services actually provided in the nursing facility.

5.101.4.3 Non-Recurring Costs

Non-recurring costs shall be capitalized and amortized and carried as an on-going adjustment beginning with the first quarterly rate change after the settlement of the cost report for a period of three years as described in the Nursing Facility Provider Manual.

5.101.4.4 Interest Expense

(a) Necessary and proper interest is an allowable cost.

(b) The Nursing Facility Provider Manual shall define when interest expenses are necessary and proper, how providers must report interest expenses, and other reporting rules related to interest expenses.

5.101.4.5 Basis of Property, Plant and Equipment

The Division shall assess the basis of donated, owned, constructed, improved, or transferred assets in accordance with the Nursing Facility Provider Manual.

5.101.4.6 Depreciation and Amortization of Property, Plant and Equipment

(a) Costs for depreciation and amortization must be based on property records sufficient in detail to identify specific assets.

(b) Providers must compute depreciation and amortization in accordance with the Nursing Facility Provider Manual.

(c) Repealed.

(d) The Division shall estimate the useful life of an asset in accordance with the Nursing Facility Provider Manual.

5.101.4.7 Change in Ownership of Depreciable Assets – Sales of Facilities

A facility may qualify for an adjustment in the basis of a depreciable asset after it has changed ownership. The Division's process for recognizing a change of ownership and the according adjustment to a depreciable asset's basis shall be provided in the Nursing Facility Provider Manual.

5.101.4.8 Repealed

5.101.4.9 Leasing Arrangements for Property, Plant and Equipment

The Division will recognize costs associated with leasing arrangements for property, plant, and equipment in accordance with the Nursing Facility Provider Manual.

5.101.4.10 Funding of Depreciation

The Division strongly recommends that providers use depreciation to conserve funds to replace depreciable assets and that providers coordinate capital expenditure planning with community and state agencies. The Division shall recognize depreciation in accordance with the Nursing Facility Provider Manual.

5.101.4.11 Adjustments for Large Asset Acquisitions and Changes of Ownership

(a) Large Asset Acquisitions

(1) A provider may apply to the Division for an adjustment to the property and related component of the rate for *individual* capital expenditures determined to be necessary and reasonable. No application for a rate adjustment should be made if the change to the rate would be smaller than one half of one percent of the facility's rate in effect at the time the application is made. Interest expense related to these assets, provided it is necessary and reasonable, shall be included in calculating the adjustment.

(2) In the event that approval is granted by the Division, the adjustment will be made effective from the first day of the quarter after the filing date of the written notice, following the date of the final order on the application, or following the date the asset is actually put into service, whichever is the latest.

(b) Changes of Ownership

(1) Application shall also be made under this section, no later than 30 days after the execution of a purchase and sale agreement or other binding contract, or the receipt of a Certificate of Need pursuant to 18 V.S.A. §9434, for changes in basis resulting from a change in ownership of depreciable assets recognized by the Division pursuant to section 5.101.4.7. The Division may make related adjustments to the Property and Related rate component.

(2) Adjustments to the Property and Related rate component resulting from a change in ownership of depreciable assets shall be effective from the first day of the month following the date of sale.

(c) Except in circumstances determined by the Division to constitute an emergency precluding a 60 day notice period, a provider applying for an adjustment pursuant to

this section is required to give 60 days written notice to the Division prior to the purchase of the asset. Such applications shall be exempt from the materiality test set out in section 5.101.8.7(b), but are subject to the other provisions of section 5.101.8.7. The burden is on the provider to document all information applicable to this adjustment and to demonstrate that any costs to be incurred are necessary and reasonable. When applicable, such documentation shall include the Certificate of Need application and all supporting financial information. The Division shall review the application and issue draft findings approving, denying, or proposing modifications to the adjustment applied for within 60 days of receipt of all information required. Providers may request review of the Division's decision in accordance with section 5.101.15 of these rules.

5.101.4.12 Repealed

5.101.4.13 Advertising Expenses

The Division shall recognize reasonable and necessary advertising expenses in accordance with the Nursing Facility Provider Manual.

5.101.4.14 Barber and Beauty Service Costs

The Division shall recognize costs related to barber and beauty services in accordance with the Nursing Facility Provider Manual.

5.101.4.15 Bad Debt, Charity and Courtesy Allowances

Providers shall not include bad debts, charitable donations, or courtesy allowances as allowable costs.

5.101.4.16 Child Day Care

The Division may recognize reasonable and necessary costs related to providing child care services to employees in accordance with the Nursing Facility Provider Manual.

5.101.4.17 Community Service Activities

The Division may recognize costs related to providing community service activities in accordance with the Nursing Facility Provider Manual.

5.101.4.18 Dental Services

The Division shall recognize costs related to dental services in accordance with the Nursing Facility Provider Manual.

5.101.4.19 Legal Costs

The Division shall recognize costs related to legal fees in accordance with the Nursing Facility Provider Manual.

5.101.4.20 Litigation and Settlement Costs

The Division shall recognize litigation and settlement costs, including costs related to challenges of the Division's decisions, in accordance with the Nursing Facility Provider Manual.

5.101.4.21 Motor Vehicle Allowance

The Division shall recognize costs to operate motor vehicles necessary to meet the needs of the facility in accordance with the Nursing Facility Provider Manual.

5.101.4.22 Non-Competition Agreement Costs

Amounts paid to the seller of an on-going facility by the purchaser for an agreement not to compete are considered capital expenditures. The amortized costs for such agreements are not allowable.

5.101.4.23 Compensation of Owners, Operators, or their Relatives

The Division shall recognize compensation for owners or operators of facilities, or their relatives, in accordance with the Nursing Facility Provider Manual..

5.101.4.24 Management Fees and Home Office Costs

(a) Management fees, home office costs and other costs incurred by a nursing facility for similar services provided by other entities shall be included in the Indirect Cost category. These costs are subject to the provisions for allowable costs, allocation of costs and related party transactions contained in these rules and shall include property and related costs incurred for the management company. These costs are allowable only if such costs would be allowable if a nursing facility provided the services for itself.

(b) Allowable costs shall be limited to five percent of the total net allowable costs less reported management fees, home office, or other costs, as defined in this section.

5.101.4.25 Membership Dues

Reasonable and necessary membership dues, including any portions used for lobbying activities, shall be considered Medicaid allowable costs, provided the organization's function and purpose are directly related to providing resident care.

5.101.4.26 Post-Retirement Benefits

The Division may recognize costs related to certain retired personnel in accordance with the Nursing Facility Provider Manual.

5.101.4.27 Public Relations

Costs incurred for services, activities and events that are determined by the Division to be for public relations purposes will not be allowed.

5.101.4.28 Related Party

The Division shall disallow costs related to a related party expense in accordance with the Nursing Facility Provider Manual. The Division may request that the provider or the related party submit information, books, and records related to related party expenses.

5.101.4.29 Revenues

The Division shall disallow costs related to revenues the facility receives for selling goods or services in accordance with the Nursing Facility Provider Manual.

5.101.4.30 Travel/Entertainment Costs

The Division shall allow costs related for meals, lodging, transportation, and incidentals incurred for purposes related to resident care in accordance with the Nursing Facility Provider Manual.

5.101.4.31 Transportation Costs

(a) Costs for ambulance services for emergency transportation or for transportation home from a nursing facility are covered pursuant to other rules promulgated by the Agency of Human Services and are not allowable under these rules.

(b) The Division shall recognize costs of transportation that a facility incurs, other than costs described in subsection (a) of this section, in accordance with the Nursing Facility Provider Manual.

5.101.4.32 Services Directly Billable

Allowable costs shall not include the cost of services to individual residents which are ordinarily billable directly to Medicaid irrespective of whether such costs are payable by Medicaid.

5.101.5 Reimbursement Standards

5.101.5.1 Prospective Case-Mix Reimbursement System

(a) The Division shall operate a prospective case-mix reimbursement system that accounts for some residents being more costly to care for than others. The Division shall require providers to assess and classify residents in accordance with the Nursing Facility Provider Manual. The Division shall weight the relative costs of caring for different classes of residents to determine an average case-mix score at each facility.

(b) Repealed.

(c) Per diem rates shall be prospectively determined for the rate year based on the allowable operating costs of a facility in a Base Year, plus property and related and ancillary costs from the most recently settled cost report, calculated as described in section 5.101.9.2.

5.101.5.2 Retroactive Adjustments to Prospective Rates

(a) In general, a final rate may not be adjusted retroactively.

(b) The Division may retroactively revise a final rate under the following conditions:

(1) as an adjustment pursuant to sections 5.101.8 and 5.101.10;

(2) in response to a decision by the Secretary pursuant to section 5.101.15.5 or to an order of a court of competent jurisdiction, whether or not that order is the result of a decision on the merits, or as the result of a settlement pursuant to section 5.101.15.8;

(3) for mechanical computation or typographical errors;

(4) for a terminating facility or a facility in receivership, pursuant to sections 5.101.5.10, 5.101.8.3, and 5.101.10.2;

(5) as a result of revised findings resulting from the reopening of a settled cost report pursuant to section 5.101.3.5;

(6) in those cases where a rate includes payment for Ancillary services and the provider subsequently arranges for another Medicaid provider to provide and bill directly for these services;

(7) recovery of overpayments, or other adjustments as required by law or duly promulgated regulation;

(8) when a special rate is revised pursuant to section 5.101.14.1(e)(2).

5.101.5.3 Lower of Rate or Charges

(a) At no time shall a facility's Medicaid per diem rate exceed the provider's average customary charges to the general public for nursing facility services in semi-private rooms at the beginning of the calendar quarter. In this section, "charges" shall mean the amount actually required to be paid by or on behalf of a resident (other than by Medicaid, Medicare Part A or the Department of Veterans Affairs) and shall take into account any discounts or contractual allowances.

(b) It is the duty of the provider to notify the Division within 10 days of any change in its charges.

(c) Rates limited pursuant to paragraph (a) shall be revised to reflect changes in the provider's average customary charges to the general public effective on the latest of the following:

(1) the first day of the month in which the change to the provider's charges is made if the changes is effective on the first day of the month,

(2) the first day of the quarter after the effective date of the change to the provider's charges if the change to the provider's charges is not effective on the first day of the quarter, or

(3) the first day of the following quarter after the receipt by the Division of notification of the change pursuant to paragraph (b).

5.101.5.4 Interim Rates

(a) The Division may set interim rates for any or all facilities. The notice of an interim rate is not a final order of the Division and is not subject to review or appeal pursuant to any provision of these rules or 33 V.S.A. § 909.

(b) Any overpayments or underpayments resulting from the difference between the interim and final rates will be either refunded by the provider or paid to the provider.

5.101.5.5 Repealed

Repealed.

5.101.5.6 Repealed

Repealed.

5.101.5.7 Occupancy Level

(a) A facility should maintain an annual average level of occupancy at a target occupancy established in the Nursing Facility Provider Manual.

(b) For facilities with less than the target occupancy amount, the number of total resident days at the target occupancy amount shall be used, pursuant to section 5.101.7, in determining the per diem rate for all categories except the Nursing Care and Ancillary categories.

(b) The target occupancy amount provision in paragraph (b) shall be waived for facilities with 20 or fewer beds or terminating facilities pursuant to section 5.101.5.10, and when appropriate, for facilities operating under a receivership pursuant to section 5.101.8.3.

(c) Decreasing the Number of Licensed Beds – For any facility that operated at less than the target occupancy amount during the period used as the cost basis for any rate component subject to subsection (b) which subsequently reduces the number of licensed beds, the minimum occupancy shall be calculated based on the number of the facility's licensed beds on the first day of the quarter after the facility notifies the Division of such reduction.

5.101.5.8 Inflation Factors

The Director shall adjust each component of the rate by an inflation factor in accordance with a procedure established in the Nursing Facility Provider Manual.

5.101.5.9 Costs for New Facilities

(a) For facilities that are newly constructed, newly operated as nursing facilities, or new to the Medicaid program, the prospective case-mix rate shall be determined based on budget cost reports submitted to the Division and the greater of the estimated resident days for the rate year or the resident days equal to the target occupancy amount established under section 5.101.5.7(a) of these rules of all beds used or intended to be used for resident care at any time within the budget cost reporting period. This rate shall remain in effect no longer than one year from the effective date of the new rate. The principles on allowability of costs and existing limits in sections 5.101.4 and 5.101.7 shall apply.

(b) The costs reported in the budget cost report shall not exceed reasonable budget projections (adjusted for inflation and changes in interest rates as necessary) submitted in connection with the Certificate of Need.

(c) Property and related costs included in the rate shall be consistent with the property and related costs in the approved Certificate of Need.

(d) At the end of the first year of operation, the prospective case-mix rate shall be revised based on the provider's actual allowable costs as reported in its annual cost report filed pursuant to section 5.101.3.2 for its first full fiscal year of operation.

5.101.5.10 Costs for Terminating Facilities

(a) When a nursing facility plans to discontinue all or part of its operation, the Division may adjust its rate so as to ensure the protection of the residents of the facility.

(b) A facility applying for an adjustment to its rate pursuant to this section must have a transfer plan approved by the Department of Disabilities, Aging and Independent Living, a copy of which shall be supplied to the Division.

(c) An application under this section shall be made on a form prescribed by the Director and shall be accompanied by a financial plan demonstrating how the provider will meet its obligations set out in the approved transfer plan.

(d) In approving such an application the Division may waive the minimum occupancy requirements in section 5.101.5.7, the limitations on costs in section 5.101.7, or make such other reasonable adjustments to the facility's reimbursement rate as shall be appropriate in the circumstances. The adjustments made under this section shall remain in effect for a period not to exceed six months.

5.101.6 Base Year Cost Categories for Nursing Facilities

5.101.6.1 General

In the case-mix system of reimbursement, allowable costs are grouped into cost categories. The accounts to be used for each cost category shall be prescribed by the Director. The Base Year costs shall be grouped into the following cost categories:

5.101.6.2 Nursing Care Costs

Providers shall allot appropriate costs to the Nursing Care component of the rate in accordance with the Nursing Facility Provider Manual.

5.101.6.3 Resident Care Costs

Providers shall allot appropriate costs to the Resident Care component of the rate in accordance with the Nursing Facility Provider Manual.

5.101.6.4 Indirect Costs

Providers shall allot appropriate costs to the Indirect component of the rate in accordance with the Nursing Facility Provider Manual.

5.101.6.5 Director of Nursing

Providers shall allot appropriate costs to the Director of Nursing component of the rate in accordance with the Nursing Facility Provider Manual.

5.101.6.6 Property and Related

Providers shall allot appropriate costs to the Property and Related component of the rate in accordance with the Nursing Facility Provider Manual.

5.101.6.7 Ancillaries

Providers shall allot appropriate costs to the Ancillaries component of the rate in accordance with the Nursing Facility Provider Manual.

5.101.7 Calculation of Costs, Limits and Rate Components for Nursing Facilities

The Division shall calculate base year costs, rates, and category limits pursuant to the Nursing Facility Provider Manual.

5.101.7.1 Repealed

Repealed.

5.101.7.2 Repealed

Repealed.

5.101.7.3 Resident Care Base Year Rate

The Division shall compute Resident Care Base Year rates in accordance with the Nursing Facility Provider Manual.

5.101.7.4 Indirect Base Year Rate

The Division shall compute Indirect Base Year rates in accordance with the Nursing Facility Provider Manual.

5.101.7.5 Director of Nursing Base Year Rate

The Division shall compute the Director of Nursing Base Year per diem rates in accordance with the Nursing Facility Provider Manual.

5.101.7.6 Ancillary Services Rate

The Division shall compute the Ancillary per diem rate in accordance with the Nursing Facility Provider Manual.

5.101.7.7 Property and Related Per Diem

The Division shall compute The Property and Related per diem rate in accordance with the Nursing Facility Provider Manual.

5.101.7.8 Limits Final

Once a final order has been issued for all facilities' Base Year cost reports, notwithstanding any subsequent changes to the cost report findings, resulting from a reopening, appeal, or other reason, any caps on increases in the Nursing Care component, the Resident Care component, or the Indirect component set forth in the Nursing Facility Provider Manual will not change until nursing home costs are rebased pursuant to 5.6(b), except for annual adjustment by the inflation factors or a change in law necessitating such a change.

5.101.8 Adjustments to Rates

5.101.8.1 Change in Services

The Division, on application by a provider, may make an adjustment to the prospective case-mix rate for additional costs which are directly related to:

(a) a new health care project previously approved under the provisions of 18 V.S.A. § 9434. Costs greater than those approved in the Certificate of Need (as adjusted for inflation) will not be considered when calculating such an adjustment,

(b) a change in services, facility, or new health care project not covered under the provisions of 18 V.S.A. § 9434, if such a change has previously been approved by the Division, or

(c) with the prior approval of the Division, a reduction in the number of licensed beds.

5.101.8.2 Change in Law

The Division may make or a provider may apply for an adjustment to a facility's prospective case-mix rate for additional costs that are a necessary result of complying with changes in applicable federal and state laws, and regulations, or the orders of a State agency that specifically requires an increase in staff or other expenditures.

5.101.8.3 Facilities in Receivership

(a) The Division, on application by a receiver appointed pursuant to state or federal law, may make an adjustment to the prospective case-mix rate of a facility in receivership for the reasonable and necessary additional costs to the facility incurred during the receivership.

(b) On the termination of the receivership, the Division shall recalculate the prospective case-mix rate to eliminate this adjustment.

5.101.8.4 Efficiency Measures

The Division, on application by a provider, may make an adjustment to a prospective case-mix rate for additional costs which are directly related to the installation of energy conservation devices or the implementation of other efficiency measures, if they have been previously approved by the Division.

5.101.8.5 Interest Rates

(a) A provider may apply for an adjustment to the Property and Related rate, or the Division may initiate an adjustment if there are cumulative interest rate increases or decreases of more than one-half of one percentage point because of existing financing agreements with a balloon payment or a refinancing clause that forces a mortgage to be refinanced at a different interest rate, or because of a variable rate of adjustable rate mortgages.

(b) A provider with an interest rate adjustment shall notify the Division of any change in the interest rate within 10 days of its receipt of notice of that change. The Division may rescind all interest rate adjustments of any facility failing to file a timely notification pursuant to this section for a period of up to two years.

5.101.8.6 Emergencies and Unforeseeable Circumstances

(a) The Division, on application by a provider, may make an adjustment to the prospective case-mix rate under emergencies and unforeseeable circumstances, such as damage from fire or flood.

(b) Providers must carry sufficient insurance to address adequately such circumstances.

5.101.8.7 Procedures and Requirements for Rate Adjustments

(a) Providers must apply for rate adjustments in accordance with this rule. The Director shall decide to grant, deny, or grant in part any application for a rate adjustment in their sole discretion.

(b) Except for applications made pursuant to section 5.101.4.11, no application for a rate adjustment should be made if the change to the rate would be smaller than one percent of the rate in effect at the time.

(a) Application for a Rate Adjustment shall be made on a form prescribed by the Director and filed with the Division and shall be accompanied by all documents and evidence determined necessary for the Division to make a decision.

(d) The burden of proof is at all times on the provider to show that the costs for which the adjustment has been requested are reasonable, necessary and related to resident care.

(e) The Division may grant or deny the Application, or make an adjustment modifying the provider's proposal. If the materials filed by the provider are inadequate to serve as a basis for a reasonable decision, the Division shall deny the Application, unless additional proofs are submitted.

(f) The Division shall not be bound in considering other Applications, or in determining the allowability of reported costs, by any prior decision made on any Application under this section. Such decisions shall have no precedential value either for the applicant facility or for any other facility.

(g) For adjustments requiring prior approval of the Division, such approval should be sought before the provider makes any commitment to expenditures. An Application for Prior Approval is subject to the same requirements as an Application for a Rate Adjustment under this section.

(h) Rate adjustments made under this section shall be effective from the first day of the quarter following the date of the final order on the application or following the date the assets are actually put into service, whichever is the later, and may be continued, at the discretion of the Division, notwithstanding a general rebase of costs. Costs which are the basis for a continuing rate adjustment shall not be included in the cost categories used as the basis for the other rate components.

(i) The Division may require an applicant for a rate adjustment under this section or under section 5.101.4.11 to file a budget cost report in support of its application.

(j) When determined to be appropriate by the Division, a budget rate may be set for the facility according to the procedures in and subject to the provisions of section 5.101.5.9. Appropriate cases may include, but are not limited to, changes in the number of beds, major changes in the services delivered to residents, an addition to the facility, or the replacement of existing property.

(k) In calculating an adjustment under this section and section 5.101.4.11, the Division may take into account the effect of such changes on all the cost categories of the facility.

(l) A revision may be made prospectively to a rate adjustment under this section and section 5.101.4.11 based on a "look-back" which will be computed based on a provider's actual allowable costs.

(m) In this section "additional costs" means the incremental costs of providing resident care directly and proximately caused by one of the events listed in this section or section 5.101.4.11. Increases in costs resulting from other causes will not be recognized. It is not intended that this section be used to effect a general rebase in a facility's costs.

5.101.8.8 Limitation on Availability of Rate Adjustments

Providers may not apply for a rate adjustment under this section for the sole reason that actual costs incurred by the facility exceed the rate of payment.

5.101.9 Private Nursing Facility and State Nursing Facility Rates

The Medicaid per diem payment rates for nursing home services are calculated according to the Nursing Facility Provider Manual.

5.101.9.1 Repealed

Repealed.

5.101.9.2 Repealed

Repealed.

5.101.9.3 Repealed

Repealed.

5.101.9.4 State Nursing Facilities

(a) Notwithstanding any other provisions of these rules, payment rates for state nursing facilities shall be determined retrospectively by the Division based on the reasonable and necessary costs of providing those services as determined using the cost reporting and cost finding principles set out in sections 5.101.3 and 5.101.4 of these rules.

(b) Until such time as the cost report is settled, the Division shall set an interim rate based on an estimate of the facility's costs and census for the rate year.

(c) After reviewing the facility's cost report, the Division shall set a final rate for the fiscal year based on the facility's allowable costs. If there has been an under payment for the period the difference shall be paid to the facility. If there has been an overpayment the excess payments shall be recouped.

5.101.9.5 Quality Incentives

The Division may make certain awards to facilities that provide a superior quality of care in an efficient and effective manner. The process for making these awards is described in the Nursing Facility Provider Manual.

5.101.10 Extraordinary Financial Relief

5.101.10.1 Objective

In order to protect Medicaid recipients from the closing of a nursing facility in which they reside, this section establishes a process by which nursing homes that are in immediate danger of failure may seek extraordinary financial relief. This process does not create any entitlement to rates in excess of those required by 33 V.S.A. Chapter 9 or to any other form of relief.

5.101.10.2 Nature of the Relief

(a) Based on the individual circumstances of each case, the Director may recommend any of the following on such financial, managerial, quality, operational or other conditions as she or he shall find appropriate: a rate adjustment, an advance of Medicaid payments, other relief appropriate to the circumstances of the applicant, or no relief.

(b) The Director's Recommendation shall be in writing and shall state the reasons for the Recommendation. The Recommendation shall be a public record.

(c) The Recommendation shall be reviewed by the Secretary who shall make a Final Decision, which shall not be subject to administrative or judicial review.

(d) In those cases where the Division determines that financial relief may be appropriate, such relief may be implemented on an interim basis pending a Final Decision by the Secretary. The interim financial relief shall be taken into account in the Division's Recommendation to the Secretary and in the Secretary's Final Decision.

5.101.10.3 Criteria to be Considered by the Division

(a) Before a provider may apply for extraordinary financial relief, its financial condition must be such that there is a substantial likelihood that it will be unable to continue in existence in the immediate future.

(b) The following factors will be considered by the Director in making the Recommendation to the Secretary:

(1) the likelihood of the facility's closing without financial assistance,

(2) the inability of the applicant to pay bona fide debts,

(3) the potential availability of funds from related parties, parent corporations, or any other source,

(4) the ability to borrow funds on reasonable terms,

(5) the existence of payments or transfers for less than adequate consideration,

(6) the extent to which the applicant's financial distress is beyond the applicant's control,

(7) the extent to which the applicant can demonstrate that assistance would prevent, not merely postpone the closing of the facility,

(8) the extent to which the applicant's financial distress has been caused by a related party or organization,

(9) the quality of care provided at the facility,

(10) the continuing need for the facility's beds,

(11) the age and condition of the facility,

(12) other factors found by the Director to be material to the particular circumstances of the facility, and

(13) the ratio of individuals receiving care in a nursing facility to individuals receiving home- and community-based services in the county in which the facility is located.

5.101.10.4 Procedure for Application

(a) An Application for Extraordinary Financial Relief shall be filed with the Division according to procedures to be prescribed by the Director.

(b) The Application shall be in writing and shall be accompanied by such documentation and proofs as the Director may prescribe. The burden of proof is at all times on the provider. If the materials filed by the provider are inadequate to serve as a basis for a reasoned recommendation, the Division shall deny the Application, unless additional proofs are submitted.

(c) The Secretary shall not be bound in considering other Applications by any prior decision made on any Application under this section. Such decisions shall have no precedential value either for the applicant facility or for any other facility.

5.101.11 Payment for Out-of-State Providers

5.101.11.1 Long-Term Care Facilities Other Than Rehabilitation Centers

Payment for services, other than Rehabilitation Center services, provided to Vermont Medicaid residents in long-term care facilities in another state shall be at the per diem rate established for Medicaid payment by the appropriate agency in that state. Payment of the per diem rate shall constitute full and final payment, and no retroactive settlements will be made.

5.101.11.2 Rehabilitation Centers

(a) Payment for prior-authorized 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) the Medicaid rate, including ancillaries as paid by at least one other state agency in CMS Region I.

(a) Payment for Rehabilitation Center services which have not been prior authorized by the Commissioner of the Department of Vermont Health Access or a designee will be made according to section 5.101.11.1.

5.101.11.3 Pediatric Care

No Medicaid payments will be made for services provided to Vermont pediatric residents in out-of-state long-term care facilities without the prior authorization of the Commissioner of the Department of Vermont Health Access.

5.101.12 Rates for ICF/IIDs

Vermont does not currently license any Intermediate Care Facilities for the Intellectually Disabled (ICF/IDs). The Division shall reimburse out-of-state ICF/IDs according to the Medicaid rate established by the state in which the ICF/ID is located.

5.101.12.1 Repealed

Repealed.

5.101.12.2 Repealed

Repealed.

5.101.13 Rates for Swing Beds and Other Long-Term Care Services in Hospitals

Payment for swing-bed and other long-term care services provided by hospitals, pursuant to 42 U.S.C. § 1396l(a), shall be made at a rate equal to the average rate per diem during the previous calendar year under the State Plan to nursing facilities located in the State of Vermont. Supplemental payments made pursuant to section 5.101.14 and section 5.101.9.5 shall not be included in the calculation of swing-bed rates.

5.101.14 Special Rates for Certain Individual Residents

5.101.14.1 Availability of Special Rates for Individuals with Unique Physical Conditions

The Division may grant a special rate for the care of an individual with unique physical conditions whose physical conditions make it otherwise extremely difficult to obtain appropriate long-term care. The process for applying for, calculating, and receiving this special rate is stated in the Nursing Facility Provider Manual.

5.101.14.2 Special Rates for Certain Former Patients of the Vermont State Hospital

The Division may grant a special rate for the care of an individual who was transferred directly from the Vermont State Hospital or to a resident who has a documented history of severe behaviors that prevent them from being placed in a nursing home. The process for applying for, calculating, and receiving this special rate is stated in the Nursing Facility Provider Manual.

5.101.14.3 Special Rates for Medicaid Eligible Individuals in the Custody of the Department of Corrections

The Division may grant a special rate for the care of an individual who is transferred directly from the custody of the Department of Corrections. The process for applying for, calculating, and receiving this special rate is stated in the Nursing Facility Provider Manual.

5.101.15 Administrative Review and Appeals

5.101.15.1 Draft Findings and Decision

(a) Before issuing findings on any Desk Review, Audit of a Cost Report, or decision on any application for a rate adjustment, the Division shall serve a draft of such findings or decision on the affected provider. If the Division makes no adjustment to a facility's reported costs or application for a rate adjustment, the Division's findings shall be final and shall not be subject to appeal under this section.

(b) The provider shall review the draft upon receipt. If it desires to review the Division's work papers, it shall file, within 10 days, a written Request for Work Papers on a form prescribed by the Director.

5.101.15.2 Request for an Informal Conference on Draft Findings and Decisions

(a) Within 15 days of receipt of either the draft findings or decision or requested work papers, whichever is the later, a provider that is dissatisfied with the draft findings or decision issued pursuant to section 5.101.15.1(a) may file a written Request for an Informal Conference with the Division's staff on a form prescribed by the Director.

(b) Within 10 days of the receipt of the Request, the Division shall contact the provider to arrange a mutually convenient time for the informal conference, which shall be held within 45 days of the receipt of the Request at the Division. The informal conference may be held by telephone. At the conference, if necessary, a date certain shall be fixed by which the provider may file written submissions or other additional necessary information. Within 20 days thereafter, the Division shall issue its official agency action.

(c) A Request for an Informal Conference must be pursued before a Request for Reconsideration can be filed pursuant to section 5.101.15.3. Issues not raised in the Request for Informal Conference shall not be raised at the informal conference or in any subsequent proceeding arising from the same action of the Division, including appeals pursuant to 33 V.S.A. §909.

(d) Should no timely Request for an Informal Conference be filed within the time period specified in section 5.101.15.2(a), the Division's draft findings and/or decision are final and no longer subject to administrative review or judicial appeal.

5.101.15.3 Request for Reconsideration

(a) A provider that is aggrieved by an official action issued pursuant to section 5.101.15.2(b) may file a Request for Reconsideration.

(b) A Request for Reconsideration must be pursued before an appeal can be taken pursuant to 33 V.S.A. 909(a).

(c) The Request for Reconsideration must be in writing, on a form prescribed by the Director, and filed within 30 days of the provider's receipt of the official action.

(d) Within 10 days of the filing of a Request for Reconsideration, the provider must file the following:

(1) A request for a hearing, if desired;

(2) A clear statement of the alleged errors in the Division's action and of the remedy requested including: a description of the facts on which the Request is based, a memorandum stating the support for the requested relief in this rule, CMS-15, or other authority for the requested relief and the rationale for the requested remedy; and

(3) If no hearing is requested, evidence necessary to bear the provider's burden of proof, including, if applicable, a proposed revision of the Division's calculations, with supporting work papers.

(e) Issues not raised in the Request for Reconsideration shall not be raised later in this proceeding or in any subsequent proceeding arising from the same action of the Division, including appeals pursuant to 33 V.S.A. §909.

(f) If a hearing is requested, within 10 days of the receipt of the Request for Reconsideration, the Division shall contact the provider to arrange a mutually agreeable time.

(g) The hearing shall be conducted by the Director or her or his designee. The testimony shall be under oath and shall be recorded either stenographically or on tape. If the provider so requests, the Division staff involved in the official action appealed shall appear and testify. The Director, or her or his designee, may hold the record open to a date certain for the receipt of additional materials.

(h) The Director shall issue a Final Order on Request for Reconsideration no later than 30 days after the record closes. Pending the issuance of a final order, the official action issued pursuant to section 5.101.15.2(b) shall be used as the basis for setting an interim rate from the first day of the calendar quarter following its issuance. Final orders shall be effective from the effective date of the official action.

(i) Proceedings under this section are not subject to the requirements of 3 V.S.A. Chapter 25.

5.101.15.4 Appeals from Final Orders of the Division

(a) Within 30 days of the date thereof, a nursing facility aggrieved by a Final Order of the Division may file an appeal pursuant to 33 V.S.A. §909(a) and sections 5.101.15.5, 5.101.15.6 and 5.101.15.7 of this rule.

(b) Within 30 days of the date thereof, a ICF/ MR aggrieved by a Final Order of the Division may file an appeal using the following procedures. Proceedings under this paragraph are not subject to the requirements of 3 V.S.A. Chapter 25.

(1) Request for Administrative Review by the Commissioner of Mental Health. The Commissioner or a designee shall review a final order of the Division of Rate Setting if a timely request is filed with the Director of the Division.

(2) Within 10 days of the receipt of the Request, the Director shall forward to the Commissioner a copy of the Request for Administrative Review and the materials that represent the documentary record of the Division's action.

(3) The Commissioner or the designee shall review the record of the appeal and may request such additional materials as they shall deem appropriate, and shall, if requested by the provider, convene a hearing on no less than 10 days written notice to the provider and the Division. Within 45 days after the close of the record, the Commissioner or the designee shall issue a decision which shall be served on the provider and the Division.

(4) Appeal to the Secretary of Human Services. Within 20 days of the date of the date of issuance, an ICF/MR aggrieved by the Commissioner's decision, may appeal to the Secretary.

(c) The Notice of Appeal shall be filed with the Commissioner, who, within 10 days of the receipt of the Notice, shall forward to the Secretary a copy of the Notice and the record of the Administrative Review.

(1) The Secretary or his designee shall review the record of the Administrative Review and may, within their sole discretion, hold a hearing, request more documentary information, or take such other steps to review the Commissioner's decision as shall seem appropriate.

(2) Within 60 days of the filing of the Notice of Appeal or the closing of the record, whichever is the later, the Secretary or the designee shall issue a Final Determination.

(d) Further review of the Final Determination is available only pursuant to Rule 75 of the Vermont Rules of Civil Procedure.

5.101.15.5 Request for Administrative Review to the Secretary of Human Services Pursuant to 33 V.S.A. § 909(a)(3)

(a) No appeal may be taken under this section when the remedy requested is retrospective relief from the operation of a provision of this rule or such other relief as may be outside the power of the Secretary to order. Such relief may be pursued by an appeal to the Vermont Supreme Court or Superior Court pursuant to 33 V.S.A. §909(a)(1) and (2), or prospectively by a request for rulemaking pursuant 3 V.S.A. §806.

(b) Appeals under this section shall be governed by the relevant provisions of the Administrative Procedures Act, 3 V.S.A. §§809-815.

(c) Proceedings under this section shall be initiated by filing two copies of a written Request for Administrative Review with the Division, on forms prescribed therefor.

(d) Within 5 days of receipt of the Request, the Director shall forward one copy to the Secretary. Within 10 days thereafter, the Secretary shall designate an independent appeals officer who shall be a registered or certified public accountant. The Letter of Designation shall be served on all parties to the appeal. All documents filed thereafter

shall be filed directly with the independent appeals officer and copies served on all parties.

(e) Within 10 days of the designation of an independent appeals officer, the Division shall forward to him or her those materials that represent the documentary record of the Division's action.

(f) Within 30 days thereafter, the independent appeals officer shall, on reasonable notice to the parties, convene a prehearing conference (which may be held by telephone) to consider such matters as may aid in the efficient disposition of the case, including but not limited to:

(1) the simplification of the issues,

(2) the possibility of obtaining stipulations of fact and/or admissions of documents which will avoid unnecessary proof,

(3) the appropriateness of prefiled testimony,

(4) a schedule for the future conduct of the case.

The independent appeals officer shall make an order which recites the action taken at the conference, including any agreements made by the parties.

(g) The independent appeals officer shall hold a hearing, pursuant to 3 V.S.A. §809, on no less than 10 days written notice to the parties, according to the schedule determined at the prehearing conference. The independent appeals officer shall have the power to subpoena witnesses and documents and administer oaths. Testimony shall be under oath and shall be recorded either stenographically or on tape. Prefiled testimony, if admitted into evidence, shall be included in the transcript, if any, as though given orally at the hearing. Evidentiary matters shall be governed by 3 V.S.A. §810.

(h) The independent appeals officer may allow or require each party to file Proposed Findings of Fact which shall contain a citation to the specific part or parts of the record containing the evidence upon which the proposed finding is based. The Proposed Findings shall be accompanied by a Memorandum of Law which shall address each matter at issue.

(i) Within 60 days after the date of the hearing, or after the filing of Proposed Findings of Fact, whichever is the later, the independent appeals officer shall file with the Secretary a Recommendation for Decision, a copy of which shall be served on each of the parties. The Recommendation for Decision shall include numbered findings of fact and conclusions of law, separately stated, and a proposed order. If a party has submitted Proposed Findings of Fact, the Recommendation for Decision shall include a ruling upon each proposed finding. Each party's Proposed Findings and Memorandum of Law shall accompany the Recommendation.

(j) At the time the independent appeals officer makes her or his Recommendation, she or he shall transmit the docket file to the Secretary. The Secretary shall retain the file for a period of at least one year from the date of the Final Determination in the docket. In the event of an appeal of the Secretary's Final Determination to the Vermont Supreme Court or to Superior Court, the Secretary shall make disposition of the file as required by the applicable rules of civil and appellate procedure.

(k) Any party aggrieved by the Recommendation for Decision may file Exceptions, Briefs, and if desired, a written Request for Oral Argument before the Secretary. These submissions shall be filed with the Secretary within 15 days of the date of the receipt of a copy of the Recommendation and copies served on all other parties.

(l) If oral argument is requested, within 20 days of the receipt of the Request for Oral Argument, the Secretary shall arrange with the parties a mutually convenient time for a hearing.

(m) Within 45 days of the receipt of the Recommendation or the hearing on oral argument, whichever is the later, the Secretary shall issue a Final Determination which shall be served on the parties.

(n) Parties may appeal the Final Determination of the Secretary pursuant to 33 V.S.A. §909(a)(1) and (2) and sections 5.101.15.6 and 5.101.15.7 of this Rule.

5.101.15.6 Appeal to Vermont Supreme Court pursuant to 33 V.S.A. § 909(a)(1)

Proceedings under this section shall be initiated, pursuant to the Vermont Rules of Appellate Procedure, as follows:

(a) by filing a Notice of Appeal from a Final Order with the Division; or

(b) by filing a Notice of Appeal from a Final Determination with the Secretary.

5.101.15.7 Appeal to Superior Court pursuant to 33 V.S.A. § 909(a)(2)

De novo review is available in the Superior Court of the county where the nursing facility is located. Such proceedings shall be initiated, pursuant to Rule 74 of the Vermont Rules of Civil Procedure, as follows:

(a) by filing a Notice of Appeal from a Final Order with the Division; or

(b) by filing a Notice of Appeal from a Final Determination with the Secretary.

5.101.15.8 Settlement Agreements

The Commissioner of the Department of Vermont Health Access or their designee may agree to settle reviews and appeals taken pursuant to sections 5.101.15.3 and 5.101.15.5, and, with the approval of the Secretary, may agree to settle other appeals taken pursuant to 33 V.S.A. § 909 and any other litigation involving the Division on such reasonable terms as she or he may deem appropriate to the circumstances of the case.