EMERGENCY RULE # _____

Administrative Procedures – Emergency Rule Filing

Instructions:

In accordance with Title 3 Chapter 25 of the Vermont Statutes Annotated and the "Rule on Rulemaking" (CVR 04-000-001) adopted by the Office of the Secretary of State, this emergency filing will be considered complete upon filing and acceptance of these forms with the Office of the Secretary of State, the Legislative Committee on Administrative Rules and a copy with the Chair of the Interagency Committee on Administrative Rules.

All forms requiring a signature shall be original signatures of the appropriate adopting authority or authorized person, and all filings are to be submitted at the Office of the Secretary of State, no later than 3:30 pm on the last scheduled day of the work week.

The data provided in text areas of these forms will be used to generate a notice of rulemaking in the portal of "Proposed Rule Postings" online, and the newspapers of record if the rule is marked for publication. Publication of notices will be charged back to the promulgating agency.

This emergency rule may remain in effect for a total of 180 days from the date it first takes effect.

Certification Statement: As the adopting Authority of this rule (see 3 V.S.A. § 801(b)(11) for a definition), I believe there exists an imminent peril to public health, safety or welfare, requiring the adoption of this emergency rule.

The nature of the peril is as follows (*PLEASE USE ADDITIONAL SHEETS IF SPACE IS INSUFFICIENT*). The COVID-19 outbreak subject of the State of Emergency proclaimed by the Governor on March 13, 2020, E.O. 01-20.

I approve the contents of this filing entitled:

Nursing Home Rate Setting Response to COVID-19.

_____, on 4-17-20.

(signature) (date)

Printed Name and Title:

Michael K. Smith, Secretary of the Agency of Human Services

RECEIVED BY: _____

- ☐ Coversheet
- ☐ Adopting Page
- ☐ Economic Impact Analysis
- ☐ Environmental Impact Analysis
- ☐ Strategy for Maximizing Public Input
- ☐ Scientific Information Statement (if applicable)
- ☐ Incorporated by Reference Statement (if applicable)
- ☐ Clean text of the rule (Amended text without annotation)
- ☐ Annotated text (Clearly marking changes from previous rule)

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I approve the contents of this filing entitled:

Nursing Home Rate Setting Response to COVID-19.

/s/ Michael K. Smith _____, on 04/17/2020

.

(signature) (date)

Printed Name and Title:

Michael K. Smith, Secretary of the Agency of Human Services

RECEIVED BY: _____

- ☐ Coversheet
- ☐ Adopting Page
- ☐ Economic Impact Analysis
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- ☐ Scientific Information Statement (if applicable)
- ☐ Incorporated by Reference Statement (if applicable)
- ☐ Clean text of the rule (Amended text without annotation)
- ☐ Annotated text (Clearly marking changes from previous rule)

1. TITLE OF RULE FILING:
   Nursing Home Rate Setting Response to COVID-19.

2. ADOPTING AGENCY:
   Department of Vermont Health Access (DVHA), Division of Rate Setting (DRS)

3. PRIMARY CONTACT PERSON:
   (A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE).

   Name: Sarah Drinkwater, Attorney

   Agency: Department of Vermont Health Access

   Mailing Address: 280 State Drive, Waterbury, VT 05676

   Telephone: 802 760 - 8552 Fax: -

   E-Mail: sarah.drinkwater@vermont.gov

   Web URL*(WHERE THE RULE WILL BE POSTED)*: dvha.vermont.gov

4. SECONDARY CONTACT PERSON:
   (A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON).

   Name: Lindsay Gillette, Director of the Division of Rate Setting

   Agency: Department of Vermont Health Access

   Mailing Address: 280 State Drive, Waterbury, VT 05676

   Telephone: 802 398 - 5282 Fax: -

   E-Mail: lindsay.gillette@vermont.gov

5. RECORDS EXEMPTION INCLUDED WITHIN RULE:
   (DOES THE RULE CONTAIN ANY PROVISION DESIGNATING INFORMATION AS CONFIDENTIAL; LIMITING ITS PUBLIC RELEASE; OR OTHERWISE EXEMPTING IT FROM INSPECTION AND COPYING?) Yes

   IF YES, CITE THE STATUTORY AUTHORITY FOR THE EXEMPTION:

   1 V.S.A. § 317(c) & 33 V.S.A. § 908(a).

   PLEASE SUMMARIZE THE REASON FOR THE EXEMPTION:

   In existing Vermont Division of Rate Setting Rules (V.D.R.S.R.) § 2.5(d), an exemption for individually identifiable health information protected by law or the policies, practices, and procedures of the Agency of

Human Services. Additionally, the salaries and wages of indivdiual employees shall not be made public.

6. LEGAL AUTHORITY / ENABLING LEGISLATION:
(THE SPECIFIC STATUTORY OR LEGAL CITATION FROM SESSION LAW INDICATING WHO THE ADOPTING ENTITY IS AND THUS WHO THE SIGNATORY SHOULD BE. THIS SHOULD BE A SPECIFIC CITATION NOT A CHAPTER CITATION).
This rule is issued pursuant to the authority vested in the Agency of Human Services by 33 V.S.A. 908(c), 33 VSA 1901(a)(1), and Act 91 of 2020 (H.742).

7. EXPLANTION OF HOW THE RULE IS WITHIN THE AUTHORITY OF THE AGENCY:
The emergency rule is within the authority of the Secretary of the Agency of Human Services to make rules required implement the statutory requirements of rate setting and to administer the Medicaid program. 33 V.S.A. 908(c) & 1901(a)(1). Additionally, Act 91 OF 2020, Section 1 directs the Agency of Human Services, of which DVHA is a department within, to consider waiving or modifying existing rules or adopting emergency rules to protect access to health care services and long-term services.

8. CONCISE SUMMARY (**150 WORDS OR LESS**):

In response to the COVID-19 State of Emergency, the emergency rule is necessary to provide financial relief to nursing homes incurring costs, occupancy changes, and changes to reporting requirements associated with COVID-19.

9. EXPLANATION OF WHY THE RULE IS NECESSARY:

The emergency rule is necessary to provide financial stability to nursing homes during the COVID-19 State of Emergency. During the COVID-19 Response, nursing homes are incurring additional costs due to staffing issues, PPE expenditures, and other associated costs. To respond to these needs, the emergency rule provides relief as detailed below.

The existing extraordinary financial relief (EFR) rule (V.D.R.S.R. § 10) limits EFRs to nursing homes that are in immediate danger of failure and require the Secretary to make the final decision on nursing home EFRs (V.D.R.S.R. § 10.2(c)). The emergency rule

expands the situations when nursing homes can apply for EFR to when they are responding to emergencies including COVID-19. In order to expedite EFRs, the emergency rule allows the Commissioner of the Department of Vermont Health Access (DVHA) to make the final decision on EFRs.

A nursing home's per diem rate is set using the average case-mix score for residents whose room and board is paid for solely by the Medicaid program. V.D.R.S.R. § 7.2(b)(1). The average case-mix score represents the individual needs of a resident and is determined from the minimum data set (MDS) reports submitted to the Department of Disabilities, Aging and Independent Living (DAIL). The type of data and schedule of the MDS collected by nursing homes is determined by CMS. CMS has issued a waiver of certain MDS reporting requirements in response to COVID-19. If nursing homes are no longer required to collect the same data or collect it on the same schedule, the Division of Rate Setting (Division) will need to use historical data to set rates. A nursing home negatively impacted by this approach could seek relief through EFR for additional costs for providing care to higher needs patients during the COVID Response or by submitting the standard MDS data directly to DAIL.

Finally, the emergency rule will allow the Division's approval of a a rate adjustment provided through V.D.R.S.R. § 8, Adjustments to Rates, to be effective retroactively. This results in a change to V.D.R.S.R. § 8.7(h) to include allowing a rate adjustment to be effective from tthe first day of the quarter immediately preceding the final order.

10. EXPLANATION OF HOW THE RULE IS NOT ARBITRARY:

On March 13, 2020, the Governor declared a State of Emergency due to the COVID-19 outbreak. Nursing homes are being directly impacted by COVID-19 including incuring costs and administartive burdens that were not contemplated in the existing rate setting rules. The emergency rule narrowly addresses these issues, providing nursing homes much needed financial support.

11. LIST OF PEOPLE, ENTERPRISES AND GOVERNMENT ENTITIES AFFECTED BY THIS RULE:

    Nursing homes receiving Vermont Medicaid.

12. BRIEF SUMMARY OF ECONOMIC IMPACT (150 WORDS OR LESS):

    The emergency rate setting methodology is expected to lessen the financial burden nursing homes are under due to the COVID-19 outbreak. The revised EFR process and rate setting mechanisms will provide financial support to these vital care providers during the State of Emergency.

13. A HEARING IS NOT SCHEDULED .

14. HEARING INFORMATION
    (THE FIRST HEARING SHALL BE NO SOONER THAN 30 DAYS FOLLOWING THE POSTING OF NOTICES ONLINE).

    IF THIS FORM IS INSUFFICIENT TO LIST THE INFORMATION FOR EACH HEARING PLEASE ATTACH A SEPARATE SHEET TO COMPLETE THE HEARING INFORMATION NEEDED FOR THE NOTICE OF RULEMAKING.

    Date:

    Time: AM

    Street Address:

    Zip Code:

    Date:

    Time: AM

    Street Address:

    Zip Code:

15. DEADLINE FOR COMMENT (NO EARLIER THAN 7 DAYS FOLLOWING LAST HEARING):

16. EMERGENCY RULE EFFECTIVE: 04/17/2020

17. EMERGENCY RULE WILL REMAIN IN EFFECT UNTIL
    (A DATE NO LATER THAN 180 DAYS FOLLOWING ADOPTION OF THIS EMERGENCY RULE):
    10/14/2020

18. NOTICE OF THIS EMERGENCY RULE SHOULD NOT BE PUBLISHED IN THE WEEKLY NOTICES OF RULEMAKING IN THE NEWSPAPERS OF RECORD.

19. KEYWORDS (PLEASE PROVIDE AT LEAST 3 KEYWORDS OR PHRASES TO AID IN THE SEARCHABILITY OF THE RULE NOTICE ONLINE).

Nursing home

Medicaid

Coronavirus

COVID-19

Administrative Procedures – Adopting Page

Instructions:

This form must accompany each filing made during the rulemaking process:

Note: To satisfy the requirement for an annotated text, an agency must submit the entire rule in annotated form with proposed and final proposed filings. Filing an annotated paragraph or page of a larger rule is not sufficient. Annotation must clearly show the changes to the rule.

When possible the agency shall file the annotated text, using the appropriate page or pages from the Code of Vermont Rules as a basis for the annotated version. New rules need not be accompanied by an annotated text.

1. TITLE OF RULE FILING:
   Nursing Home Rate Setting Response to COVID-19.
2. ADOPTING AGENCY:
   Department of Vermont Health Access (DVHA), Division of Rate Setting (DRS)
3. TYPE OF FILING (*PLEASE CHOOSE THE TYPE OF FILING FROM THE DROPDOWN MENU BASED ON THE DEFINITIONS PROVIDED BELOW*):
   - **AMENDMENT -** Any change to an already existing rule, even if it is a complete rewrite of the rule, it is considered an amendment as long as the rule is replaced with other text.
   - **NEW RULE -** A rule that did not previously exist even under a different name.
   - **REPEAL** - The removal of a rule in its entirety, without replacing it with other text.

   This filing is **AN AMENDMENT OF AN EXISTING RULE** .

4. LAST ADOPTED (*PLEASE PROVIDE THE SOS LOG#, TITLE AND EFFECTIVE DATE OF THE LAST ADOPTION FOR THE EXISTING RULE)*:

   SOS log# 15-002

   CVR 13-010-001 - Methods, Standards and Principles for Establishing Payment Rates for Long-Term Care Facilities (V.D.R.S.R.)

   Effective March 6, 2015

Administrative Procedures – Economic Impact Analysis

Instructions:

In completing the economic impact analysis, an agency analyzes and evaluates the anticipated costs and benefits to be expected from adoption of the rule; estimates the costs and benefits for each category of people enterprises and government entities affected by the rule; compares alternatives to adopting the rule; and explains their analysis concluding that rulemaking is the most appropriate method of achieving the regulatory purpose.

Rules affecting or regulating schools or school districts must include cost implications to local school districts and taxpayers in the impact statement, a clear statement of associated costs, and consideration of alternatives to the rule to reduce or ameliorate costs to local school districts while still achieving the objectives of the rule (see 3 V.S.A. § 832b for details).

Rules affecting small businesses (excluding impacts incidental to the purchase and payment of goods and services by the State or an agency thereof), must include ways that a business can reduce the cost or burden of compliance or an explanation of why the agency determines that such evaluation isn't appropriate, and an evaluation of creative, innovative or flexible methods of compliance that would not significantly impair the effectiveness of the rule or increase the risk to the health, safety, or welfare of the public or those affected by the rule.

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1. TITLE OF RULE FILING:

   Nursing Home Rate Setting Response to COVID-19.

2. ADOPTING AGENCY:

   Department of Vermont Health Access (DVHA), Division of Rate Setting (DRS)

3. CATEGORY OF AFFECTED PARTIES:

   LIST CATEGORIES OF PEOPLE, ENTERPRISES, AND GOVERNMENTAL ENTITIES POTENTIALLY AFFECTED BY THE ADOPTION OF THIS RULE AND THE ESTIMATED COSTS AND BENEFITS ANTICIPATED:

   Privately owened nursing facilities providing services to Medicaid residents.

4. IMPACT ON SCHOOLS:

   INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON PUBLIC EDUCATION, PUBLIC SCHOOLS, LOCAL SCHOOL DISTRICTS AND/OR TAXPAYERS CLEARLY STATING ANY ASSOCIATED COSTS:

   None anticipated.

5. ALTERNATIVES: *CONSIDERATION OF ALTERNATIVES TO THE RULE TO REDUCE OR AMELIORATE COSTS TO LOCAL SCHOOL DISTRICTS WHILE STILL ACHIEVING THE OBJECTIVE OF THE RULE.*

   N/A

6. IMPACT ON SMALL BUSINESSES:
   INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON SMALL BUSINESSES (EXCLUDING IMPACTS INCIDENTAL TO THE PURCHASE AND PAYMENT OF GOODS AND SERVICES BY THE STATE OR AN AGENCY THEREOF):

   The emergency rule will provide financial support to nursing homes which may be small business by providing additional financial support for COVID-19 related costs and administratie burdens.

7. SMALL BUSINESS COMPLIANCE: *EXPLAIN WAYS A BUSINESS CAN REDUCE THE COST/BURDEN OF COMPLIANCE OR AN EXPLANATION OF WHY THE AGENCY DETERMINES THAT SUCH EVALUATION ISN'T APPROPRIATE.*

   The emergency rule does not create additional compliance burdens and, may reduce amdinsitrative burdens to nursing homes.

8. COMPARISON:
   COMPARE THE IMPACT OF THE RULE WITH THE ECONOMIC IMPACT OF OTHER ALTERNATIVES TO THE RULE, INCLUDING NO RULE ON THE SUBJECT OR A RULE HAVING SEPARATE REQUIREMENTS FOR SMALL BUSINESS:
   Without the emergency rule, the financial relief to these vital service providers would be limited. The emergency rule provides financial suppoort to nursing facilities to increase their viability during these difficult times as well as into the future. These facilities are vital to the long-term health care delivery system in Vermont.

9. SUFFICIENCY: *EXPLAIN THE SUFFICIENCY OF THIS ECONOMIC IMPACT ANALYSIS.*
   In light of the urgency of responding to the COVID-19 outbreak, the analysis descried herein is sufficient to enact the emergency rule. The cost of the substantive changes are minimal in comparison to the net positive to providers.

Administrative Procedures – Environmental Impact Analysis

Instructions:

In completing the environmental impact analysis, an agency analyzes and evaluates the anticipated environmental impacts (positive or negative) to be expected from adoption of the rule; compares alternatives to adopting the rule; explains the sufficiency of the environmental impact analysis.

Examples of Environmental Impacts include but are not limited to:

- Impacts on the emission of greenhouse gases
- Impacts on the discharge of pollutants to water
- Impacts on the arability of land
- Impacts on the climate
- Impacts on the flow of water
- Impacts on recreation
- Or other environmental impacts

---

1. TITLE OF RULE FILING:

   Nursing Home Rate Setting Response to COVID-19.

2. ADOPTING AGENCY:

   Department of Vermont Health Access (DVHA), Division of Rate Setting (DRS)Department of Vermont Health Access (DVHA), Division of Rate Setting (DRS)

3. GREENHOUSE GAS: *EXPLAIN HOW THE RULE IMPACTS THE EMISSION OF GREENHOUSE GASES (E.G. TRANSPORTATION OF PEOPLE OR GOODS; BUILDING INFRASTRUCTURE; LAND USE AND DEVELOPMENT, WASTE GENERATION, ETC.):*

   None anticipated.

4. WATER: *EXPLAIN HOW THE RULE IMPACTS WATER (E.G. DISCHARGE / ELIMINATION OF POLLUTION INTO VERMONT WATERS, THE FLOW OF WATER IN THE STATE, WATER QUALITY ETC.):*

   None anticipated.

5. LAND: *EXPLAIN HOW THE RULE IMPACTS LAND (E.G. IMPACTS ON FORESTRY, AGRICULTURE ETC.):*

   None anticipated.

6. RECREATION: *EXPLAIN HOW THE RULE IMPACT RECREATION IN THE STATE:*

   None anticipated.

7. CLIMATE: *EXPLAIN HOW THE RULE IMPACTS THE CLIMATE IN THE STATE:*

   None anticipated.

8. OTHER: *EXPLAIN HOW THE RULE IMPACT OTHER ASPECTS OF VERMONT'S ENVIRONMENT:*
   None anticipated.

9. SUFFICIENCY: *EXPLAIN THE SUFFICIENCY OF THIS ENVIRONMENTAL IMPACT ANALYSIS.*
   The emergency rule is not anticipated to have any environmental impacts and the analysis is, therefore, sufficient.

Administrative Procedures – Public Input

Instructions:

In completing the public input statement, an agency describes the strategy prescribed by ICAR to maximize public input, what it did do, or will do to comply with that plan to maximize the involvement of the public in the development of the rule.

This form must accompany each filing made during the rulemaking process:

1. TITLE OF RULE FILING:

   Nursing Home Rate Setting Response to COVID-19.

2. ADOPTING AGENCY:

   Department of Vermont Health Access (DVHA), Division of Rate Setting (DRS)

3. PLEASE DESCRIBE THE STRATEGY PRESCRIBED BY ICAR TO MAXIMIZE PUBLIC INVOLVEMENT IN THE DEVELOPMENT OF THE PROPOSED RULE:

   Not Applicable.

4. PLEASE LIST THE STEPS THAT HAVE BEEN OR WILL BE TAKEN TO COMPLY WITH THAT STRATEGY:

   The emergency rule will be posted on DVHA's website and will be sent electronically to each impacted nursing home.

5. BEYOND GENERAL ADVERTISEMENTS, PLEASE LIST THE PEOPLE AND ORGANIZATIONS THAT HAVE BEEN OR WILL BE INVOLVED IN THE DEVELOPMENT OF THE PROPOSED RULE:

   In light of the unprecedented urgency of addressing the COVID-19 State of Emergency, DVHA has not sought extensive public comment on this emergency rule. The emergency rule was drafted in coordination with DAIL and AHS Central Office.

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

Emergency Rule
April 17, 2020

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1 GENERAL PROVISIONS

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).

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, and Intermediate Care Facilities for the Mentally Retarded are reimbursed under different methods and standards. Swing-bed hospitals are reimbursed pursuant to 42 U.S.C. §1396l(b)(1). Intermediate Care Facilities for the Mentally Retarded are reimbursed pursuant to the *Regulations Governing the Operation of Intermediate Care Facilities for the Mentally Retarded* adopted by the Agency and are subject to the Division's Accounting Requirements (Section 2) and Financial Reporting (Section 3).

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).

1.4 General Description of the Rate Setting System

A prospective case-mix payment system for nursing facilities is established by these rules 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.

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 Subsection 1.5(a).

1.6 Responsibilities of Owners

The owner of a nursing facility shall prudently manage and operate a residential health care program of adequate quality to meet its residents' needs. Neither the issuance of a per diem rate, nor final orders made by the Director or a duly authorized representative shall in any way relieve the owner of a nursing facility from full responsibility for compliance with the requirements and standards of the Agency of Human Services.

1.7 Duties of the Owner

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

(a) Comply with the provisions of Subsections 1.5 and 1.6 setting forth the requirements for participation in the Medicaid Program.

(b) Submit cost reports in accordance with the provisions of subsections 3.2 and 3.3 of these rules.

(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 subsection 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.

1.8 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 or related party or organization to file such relevant and appropriate data, statistics, schedules or information as the Division finds necessary to enable it to carry out its function.

(c) The Division may examine books and accounts of any nursing facility and related parties 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) Copies of each notice of practice and procedure, form, or set of instructions shall be sent to each nursing facility participating in the Medicaid program at the time it is issued. A compilation of all such documents currently in force shall be maintained at the Division, pursuant to 3 V.S.A. §835, and shall be available to the public.

(g) Neither the issuance of final per diem rates nor Final Orders of the Division which fail, in any one or more instances, to enforce the performance of any of the terms or conditions of these rules shall be construed as

a waiver of the Division's future performance of the right. The obligations of the provider with respect to performance shall continue, and the Division shall not be estopped from requiring such future performance.

1.9 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 upon the federal RUG IV classification system (48 group version). 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.

1.10 Computation of and Enlargement of Time; Filing and Service of Documents

(a) In computing any period of time prescribed or allowed by these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a state or federal legal holiday, in which event the period runs until the end of the next day which is not a Saturday, a Sunday, or a state or federal legal holiday.

(b) For the purposes of any provision of these rules in which time is computed from the receipt of a notice or other document issued by the Division or other relevant administrative officer, the addressee of the notice shall be rebuttably presumed to have received the notice or other document three days after the date on the document.

(c) When by these rules or by a notice given thereunder, an act is required or allowed to be done at or within a specified time, the relevant administrative officer, for just cause shown, may at any time in her or his discretion, with or without motion or notice, order the period enlarged. This subsection 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.

(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, October 29, 2007, August 25, 2008, April 1, 2011, September 17, 2012, September 9, 2013, and March 6, 2015).

(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 reports and the non-accrual fiscal accounts.

The provider shall retain all such documentation for audit purposes.

2.2 Procurement Standards

(a) Providers shall establish and maintain a code of standards to govern the performance of its employees engaged in purchasing goods and services. Such standards shall provide, to the maximum extent practical, open and free competition among vendors. Providers should participate in group purchasing plans when feasible.

(b) If a provider pays more than a competitive bid for a good or service, any amount over the lower bid which cannot be demonstrated to be a reasonable and necessary expenditure that satisfies the prudent buyer principle is a nonallowable cost.

2.3 Cost Allocation Plans and Changes in Accounting Principles

With respect to the allocation of costs to the nursing facility and within the nursing facility, the following rules shall apply:

(a) [Repealed]

(b) Providers that have costs allocated from related entities included in their cost reports shall include, as a part of their cost report submission, a summary of the allocated costs, including a reconciliation of the allocated costs to the entity's financial statements, which must also be submitted with the Medicaid cost report. In the case of a home office or related management company, this would include a completed Home Office Cost Statement. The provider shall submit this reconciliation with the Medicaid cost report.

(c) The Division reserves the right not to recognize changes in accounting principles or methods or basis of cost allocation made for the purpose or having the likely effect of increasing a facility's Medicaid payments.

(d) [Repealed]

(e) [Repealed]

(f) Each provider shall notify the Division of changes in statistical allocations or record keeping required by the Medicare Intermediary.

(g) Preferred statistical methods of allocation are as follows:

(1) Nursing salaries and supplies - direct cost,

(2) Plant operations - square footage,

(3) Utilities - square footage,

(4) Laundry - pounds of laundry,

(5) Dietary -resident days,

(6) Administrative and General - accumulated costs,

(7) [Repealed]

(8) Property and Related - square footage,

(9) Fringe Benefits - direct allocation/gross salaries.

(h) Food costs included in allocated dietary costs are calculated by dividing the facility's allocated dietary costs by total organization dietary costs, both of which include allocated overhead, and multiplying the result by the total organization food costs.

(i) Utility costs included in allocated plant operation and maintenance costs are calculated by dividing the facility's plant operation and maintenance costs by total organization plant operation and maintenance cost, both of which include allocated overhead, and multiplying the result by the total organization utility costs.

(j) All administrative and general costs, including home office and management

company costs, allocated to a facility shall be included in the Indirect Cost category.

(k) The capital component of goods or services purchased or allocated from a related or unrelated party, such as plant operation and maintenance, utilities, dietary, laundry, housekeeping, and all others, whether or not acquired from a related party, shall be considered as costs for that particular good or service and not classified as Property and Related costs of the nursing facility.

(l) Costs allocated to the nursing facility shall be reasonable, as determined by the Division pursuant to these rules.

2.4 Substance Over Form

The cost effect of transactions that have the effect of circumventing the intention of these rules may be adjusted by the Division on the principle that the substance of the transaction shall prevail over the form.

2.5 Record Keeping and Retention of Records

(a) Each provider must maintain complete documentation, including accurate financial and statistical records, to substantiate the data reported on the uniform financial and statistical report (cost report), and must, upon request, make these records available to the Division of Rate Setting, or the U. S. Department of Health and Human Services, and the authorized representatives of both agencies.

(b) 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.

(c) 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.

(d) 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. With the exception of the administrator's salary, the salaries and wages of individual employees shall not be made public.

3 FINANCIAL REPORTING

3.1 [Repealed]

3.2 Uniform Cost Reports

(a) Each long-term care facility participating in the Vermont Medicaid program shall annually submit a uniform financial and statistical report (cost report) on forms prescribed by the Division. The inclusive dates of the reporting year shall be the 12

month period of each provider's fiscal year, unless advance authorization to submit a report for a greater or lesser period has been granted by the Division.

(1) The Division may require providers to file special cost reports for periods other than a facility's fiscal year.

(2) The Division may require providers to file budget cost reports. Such cost reports may be used inter alia as the basis for new facilities' rates or for rate adjustments.

(b) The cost report must include the certification page signed by the owner, or its representative, if authorized in writing by the owner.

(c) The original and one copy of the cost report must be submitted to the Division. All documents must bear original signatures.

(d) The following supporting documentation is required to be submitted with the cost report:

(1) Audited financial statements (except that at the discretion of the Director, this requirement may be waived),

(2) Most recently filed Medicare Cost Report with the required supplemental data on CMS Form 339 (if a participant in the Medicare Program), which for hospital-based nursing homes shall be the Medicare cost report for the same fiscal year as the Medicaid cost report,

(3) Independent auditor's adjusting entries and reconciliation of the audited financial statements to the cost report.

(e) A provider must also submit, upon request during the desk review or audit process, such data, statistics, schedules or other information which the Division requires in order to carry out its function. If, before the draft findings are issued, the facility has been specifically requested to provide certain information or materials and has failed to do so, such information or materials will not be admissible in any subsequent appeal taken pursuant to Section 15, provided the Division has notified the provider of such failure and afforded the provider a final opportunity to cure.

(f) Providers shall follow the cost report instructions prescribed by the Director in completing the cost report. The chart of accounts prescribed by the Director, shall be used as a guideline providing the titles, and description for type of transactions recorded in each asset, liability, equity, income, and expense account.

3.3 Adequacy and Timeliness of Filing

(a) With the exception of hospital-based nursing homes, an acceptable cost report filing shall be made on or before the last day of the fifth month following the close of the period covered by the report.

(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.

(b) The Division may reject any filing which does not comply with these regulations and/or the cost reporting instructions. In such case, the report shall be deemed not filed, until refiled and in compliance.

(c) Extensions for filing of the cost report beyond the prescribed deadline must be requested as follows:

(1) All Requests for Extension of Time to File Cost Report must be in writing, on a form prescribed by the Director, and must be received by the Division of Rate Setting prior to the due date. The provider must

clearly explain the reason for the request and specify the date on which the Division will receive the report.

(2) Notwithstanding any previous practice, the Division will not grant automatic extensions. Such extensions will be granted for good cause only, at the Director's sole discretion, based on the merits of each request. A "good cause" is one that supplies a substantial reason, one that affords a legal excuse for the delay or an intervening action beyond the provider's control. The following are not considered "good cause": ignorance of the rule, inconvenience, or a cost report preparer engaged in other work.

(d) Notwithstanding any other provision of these rules, any provider that fails to make a complete cost report filing within the time prescribed in subsection 3.3(a) or within an extension of time approved by the Division, shall be subject to the provisions of subsection 1.7(f).

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.

(c) The procedure for issuing and reviewing Summaries of Findings is set out in Subsections 15.1, 15.2 and 15.3.

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 Subsection 15.3 of these rules.

(b) Cost report determinations and decisions, otherwise final, may be reopened and corrected when the specific requirements set out below are met. The Division's decision to reopen will be based on new and material evidence submitted by the provider, evidence of a clear and obvious material error, or a determination by the Secretary or a court of competent jurisdiction that the determination is inconsistent with applicable law, regulations and rulings, or general instructions.

(c) Reopening means an affirmative action taken by the Division to re-examine the correctness of a determination or decision otherwise final. Such action may be taken:

(1) On the initiative of appropriate authority within the applicable time period set out in paragraph (f), or

(2) In response to a written request of the provider or other relevant entity, filed with the Division within the applicable time period set out in subsection (f), and

(3) When the reopening has a material effect (more than one percent) on the provider's Medicaid rate payments.

(d) A correction is a revision (adjustment) in the Division's determination or Secretary's decision, otherwise final, which is made after a proper re-opening.

(e) A correction may be made by the Division, or the provider may be required to file an amended cost report. If the cost report is reopened by an order of the Secretary or a court of competent jurisdiction, the correction shall be made by the Division.

(f) A determination or decision may be reopened within three years from the date of the notice containing the Division's determination, or the date of a decision by the Secretary or a court.

(g) The Division may also require or allow an amended cost report to correct material errors detected subsequent to the filing of the original cost report or to comply with applicable standards and regulations. Once a cost report is filed, the provider is bound by its elections. The Division shall not accept an amended cost report to avail the provider of an option it did not originally elect.

4 DETERMINATION OF ALLOWABLE COSTS FOR NURSING FACILITIES

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, 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 regulations 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 subsection.

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.

4.3 Non-Recurring Costs

(a) Non-recurring costs shall include:

(1) any reasonable and resident-related cost that exceeds $10,000, which is not expected to recur on an annual basis in the ordinary operation of the facility, may be designated by the Division as a "Non-Recurring Cost" subject to any limits on the cost category into which the type of cost would otherwise be assigned,

(2) litigation expenses of $10,000 or more, recognized pursuant to subsection 4.20.

(3) allowable lump-sum costs of $2,000 or more per cost reporting period for recruitment and legal fees or similar expenses associated with the hiring of registered nurses from countries outside the United States on condition that such fees or expenses shall be allowable only in respect of such nurses who are paid at least the prevailing salary/wage and benefits for employed nurses of similar qualifications and experience in the geographic area in which the facility is located or tuition expenses for nurse aide training reimbursed pursuant to 42 C.F.R. §483.152(c)(2).

(b) A non-recurring cost 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.

4.4 Interest Expense

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

(b) “Necessary requires that:

(1) The interest be incurred on a loan made to satisfy a financial need of the provider.

(2) A financial need does not exist if the provider has cash and/or cash equivalents of more than 60 days cash needs.

(3) Cash and cash equivalents include:

(i) monetary investments, including unrestricted grants and gifts,

(ii) non-monetary investments not related to resident care that can readily be converted to cash net of any related liability,

(iii) receivables from (net of any payables to) officers, owners, partners, parent organizations, brother/sister organizations, or other related parties, excluding education loans to employees.

(iv) receivables that result from transactions not related to resident care.

(4) Cash and cash equivalents exclude:

(i) funded depreciation recognized by the Division,

(ii) restricted grants and gifts.

(5) Interest income offset.

(i) Interest expense shall be reduced by realized investment income, except where such income is from:

(A) funded depreciation recognized by the Division pursuant to CMS-15,

(B) grants and gifts, whether restricted or unrestricted.

(ii) Only working capital interest expense shall be offset by interest income derived from working capital.

(6) The provider must have a legal obligation to pay the interest.

(c) "Proper" requires that:

(1) Interest be incurred at a rate not in excess of what a prudent buyer would have

had to pay in the money market existing at the time the loan was made.

(2) Interest must be paid to a lender that is not a related party of the borrowing organization except as provided in paragraph (k).

(d) Interest expense shall be included in property costs if the interest is necessary and proper and if it is incurred as a result of financing the acquisition of fixed assets related to resident care.

(e) The date of such financing must be within 60 days of the date the asset is put in use, except for assets approved through the Certificate of Need process or approved by the Division under Subsection 4.11 of this rule. Allowable interest, on loans financed more than 60 days before or after the asset is put in use, will be included in Indirect Costs for the entire term of the loan.

(f) Borrowings to finance asset additions cannot exceed the sum of the basis of the asset(s), determined in accordance with Subsections 4.5 and 4.7, and other costs allowed pursuant to paragraph (g) related to the borrowing. The limit on borrowings related to fixed assets is determined as follows:

Basis of the assets recognized by the Division, plus a proportionate share of other costs allowed pursuant to paragraph (g), or

the principal amount of the loan, whichever is the lower:

Less: The provider's cash and cash equivalents in excess of 60 days needs, per subparagraph (b)(2) of this subsection.

Equals: The limits on borrowings related to fixed assets.

(g) Other costs related to the acquisition of the assets may be included in loans where the interest is recognized by the Division. These costs include bank finance charges, points and costs for legal and accounting fees, and discounts on debentures and letters of credit.

(h) Necessary and proper interest expense on debt incurred other than for the acquisition of assets shall be recognized as working capital interest expense and included in Indirect Costs.

(i) Application of Principal Payments.

(1) For loans entered into before a facility's 1998 fiscal year, principal payments shall be applied first to loan balances on allowable borrowings and second to non-allowable loan balances.

(2) For loans entered into during or after a facility's 1998 fiscal year, principal payments shall be applied to allowable and non-allowable loan balances on the ratio of each to the total amount of the loan.

(j) Refinancing of indebtedness.

(1) The provider must demonstrate to the Division that the costs of refinancing will be less than the allowable costs of the current financing.

(2) Costs of refinancing must include accounting fees, legal fees and debt acquisition costs related to the refinancing.

(3) Material interest expense related to the original loan's unpaid interest charges, to the extent that it is included in the refinanced loan's principal, shall not be allowed.

(4) A principal balance in excess of the sum of the principal balance of the previous financing plus accounting fees, legal fees and debt acquisition costs shall be considered a working capital loan, subject to the cash needs test in subsection 4.4(b)(2), unless the provider demonstrates to the Division that the excess was for the acquisition of assets as set forth in (a) through (g).

(k) Interest expense incurred as a result of transactions with a related party (or related parties) will be recognized if the expense would otherwise be allowable and if the following conditions are met:

(1) The interest expense relates to a first and/or second mortgage or to assets leased from a related party where the costs to the related party are recognized in lieu of rent.

(2) The interest rate is no higher than the rate charged by lending institutions at the inception of the loan.

(l) Interest is not allowable with respect to any capital expenditure in property, plant and equipment related to resident care which requires approval, if the necessary approval has not been granted.

(m) Interest on loans that do not include reasonable and ordinary principle repayments in the debt service payments shall not be allowable except to the extent that it would have been incurred pursuant to a standard amortization schedule for a term equivalent to the useful life of the asset.

4.5 Basis of Property, Plant and Equipment

(a) The basis of a donated asset is the fair market value.

(b) The basis of other assets that are owned by a provider and used in providing resident care shall generally be the lower of cost or fair market value. Specific exceptions are addressed elsewhere in this rule. Cost includes:

(1) purchase price,

(2) sales tax,

(3) costs to prepare the asset for its intended use, such as, but not limited to, costs of shipping, handling, installation, architectural fees, consulting and legal fees.

(c) The basis of assets constructed by the provider to provide resident care shall be determined from the construction costs which include:

(1) all direct costs, including, but not limited to, salaries and wages, the related payroll taxes and fringe benefits, purchase price of materials, sales tax, costs of shipping, handling and installation, costs for permits, architectural fees, consulting fees and legal fees.

(2) indirect costs related to the construction of the asset.

(3) interest costs related to capital indebtedness used to finance the construction of the asset and prepare it for its intended use.

(d) The basis of betterments or improvements, if they extend the useful life of an asset two or more years or significantly increase the productivity of an asset are costs as set forth in paragraphs (b) and (c) above.

(e) Any asset that has a basis of $2,000 or more and an estimated useful life of two or more years must be capitalized and depreciated in accordance with Subsection 4.6. Groups of assets with the majority of assets in the group valued at $300 or more and a useful life of two years or more must also be capitalized and depreciated in accordance with Subsection 4.6. Assets or groups of assets with a basis lower than $2,000 may be expensed or depreciated at the provider's election.

(f) The gain on a transfer of an asset to a related party shall be calculated as follows: the fair market value of the asset, less the net book value will be the gain irrespective of the of the amount paid to the facility for the asset. This gain will be offset against property and related costs.

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) Depreciation and amortization must be computed on the straight-line method.

(c) The depreciable basis of an asset shall be the basis established according to Subsections 4.5 and 4.7, net of any salvage value.

(d) The estimated useful life of an asset shall be determined by the Division as follows:

(1) The recommended useful life is the number of years listed in the most recent edition of Estimated Useful Lives of Depreciable Hospital Assets, published by the American Hospital Association.

(2) Leasehold improvements may be amortized over the term of an arms-length lease, including renewal period, if such a lease term is shorter than the estimated useful life of the asset.

4.7 Change in Ownership of Depreciable Assets - Sales of Facilities

(a) A change of ownership will be recognized when the following criteria have been met:

(1) The change of ownership did not occur between related parties, except for transactions that meet the criteria in subparagraph (2).

(2) The transaction takes place between family members and meets the following conditions:

(i) The Division shall be notified at least two years before the sale. The notice shall include a description of the terms and conditions of the sale and be accompanied by a current appraisal of the facility being sold.

(ii) The buyer shall demonstrate the capacity to manage and/or administer the facility; or if the buyer is to be an absentee owner, the buyer shall demonstrate that there will be sufficient capable staff to operate the facility according to standards prescribed by state and federal law.

(iii) The seller shall not maintain full time employment with the facility, except for a transition period which shall not be longer than one year during which the seller may provide reasonable consultation to assure a smooth transition.

(iv) A sale of the facility shall not have occurred between any members of the same family within the previous 12 years.

(v) For the purposes of this subsection, family members shall include spouses, parents, grandparents, children, grandchildren, brothers, sisters, spouses of parents, grandparents, children, grandchildren, brothers and sisters, aunts, uncles, nieces and nephews, or such other familial relationships as the Director may reasonably approve in the circumstances of the transaction.

(3) The change of ownership was made for reasonable consideration.

(4) The change of ownership was a bona fide transfer of all the powers and indicia of ownership.

(5) The change in ownership is in substance the sale of the assets or stock of the facility and not a method of financing.

(i) If the transferor and the transferee enter into a financing agreement, the agreement must be constructed to effect a complete change of ownership. The Division shall determine if the agreement does in substance effect a complete change of ownership and the Division shall monitor the compliance with the agreement.

(ii) Where, subsequent to a change of ownership, the transferor forgives or reduces the debt of the transferee, the amount of the forgiveness or reduction shall be retroactively applied to the acquisition or basis of the asset as determined by the Division.

(6) The buyer shall demonstrate to the satisfaction of the Division that all obligations to the State of Vermont arising out of the transaction have been satisfied.

(7) For rate setting purposes, the transfer of stock or shares shall not be recognized as a change in ownership in the following circumstances:

(i) the transferred stock or shares are those of a publicly traded corporation.

(ii) the transfer was made solely as a method of financing (not as a method of transferring management or control) and the number of shares transferred does not exceed 25 percent of the total number of shares in any one class of stock.

(b) Where the Division recognizes the change in ownership of an asset, the basis of the assets for the new owner shall be determined as follows:

(1) If the seller did not own the assets during the entire twelve year period immediately preceding the change in ownership or if the seller's facility did not receive Vermont Medicaid reimbursement during the entire twelve year period immediately preceding the change in ownership, the depreciable cost basis of the transferred asset for the new owner shall be the lowest of:

(i) the fair market value of the assets,

(ii) the acquisition cost of the asset to the buyer,

(iii) the original basis of the asset to the seller as recognized by the Division, less accumulated depreciation.

(2) If the seller owned the assets during the entire twelve year period immediately preceding the change in ownership and if the seller's facility received Vermont Medicaid reimbursement during the entire twelve year period immediately preceding the change in ownership, the depreciable cost basis of the transferred fixed equipment and building improvements for individual assets having an original useful life of at least 20 years in agreement with the useful life assigned in the American Hospital Association guidelines, the depreciable cost basis of land improvements, the depreciable cost basis of buildings and the cost basis of land for the new owner shall be the lowest of:

(i) the fair market value of the assets,

(ii) the acquisition cost of the asset to the buyer,

(iii) the amount determined by the revaluation of the asset. An asset is revalued by increasing the original basis of the asset to the seller, as recognized by the Division, by an annual percentage rate. The annual percentage rate will be limited to the lower of:

(A) One-half the percentage increase in the Consumer Price Index (CPI) for All Urban consumers (United States City Average).

(B) One-half the percentage change in an appropriate construction cost index as determined by the Division of Rate Setting, which change shall not be greater than one-half of the percentage increase in the Dodge Construction index (or a reasonable proxy therefor) for the same period.

(3) If the seller owned the assets during the entire twelve year period immediately preceding the change in ownership and if the seller's facility received Vermont Medicaid reimbursement during the entire twelve year period immediately preceding the change in ownership, the depreciable cost basis of individual assets categorized as building improvements and fixed equipment with an original useful life of less than 20 years, in agreement with the useful life assigned in the American Hospital Association guidelines, shall be the seller's net book value and shall be depreciated over a useful life of seven years.

(4) If the seller owned the assets during the entire twelve year period immediately preceding the change in ownership and if the seller's facility received Vermont Medicaid reimbursement during the entire twelve year period immediately preceding the change in ownership, the depreciable cost basis of moveable equipment and vehicles shall be the seller's net book value and shall be depreciated over a useful life of ten years.

4.8 [Repealed]

4.9 Leasing Arrangements for Property, Plant and Equipment

Leasing arrangements for property, plant and equipment must meet the following conditions:

(a) Rent expense on facilities and equipment leased from a related organization will be limited to the Medicaid allowable interest, depreciation, insurance and taxes incurred for the year under review, or the price of comparable services or facilities purchased elsewhere, whichever is lower.

(b) Rental or leasing charges, including sale and leaseback agreements for property, plant and equipment to be included in allowable costs cannot exceed the amount which the provider would have included in allowable costs had it purchased or retained legal title to the asset, such as interest on mortgage, taxes, insurance and depreciation.

4.10 Funding of Depreciation

(a) Funding of depreciation is not required, but it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciable assets, and coordinate their planning of capital expenditures with area-wide planning of community and state agencies. As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense.

(b) To the extent that the provider fails to retain sufficient working capital or sufficient resources to support operations, before making deposits in a funded depreciation account, the deposits will not be recognized as funded depreciation.

(c) To the extent that funded depreciation in the cost reporting period under consideration is used for purposes other than nursing facility asset acquisition, interest income on those sums will be offset against interest expense not only in the current period, but the Division may reopen settled cost reports for previous periods to revise funded depreciation and allowable interest expense. However, with the prior approval of the Division, under appropriate conditions, some or all of a provider's funded depreciation may be used as follows without triggering an interest income offset:

(1) to convert existing nursing home beds to residential care or assisted living, or

(2) when more economic, for new construction of residential care or assisted living units with a reduction in licensed nursing home beds.

(d) All relevant provisions of CMS-15 shall be followed, except as noted below:

(1) Replacement reserves. Some lending institutions require funds to be set aside periodically for replacement of fixed assets. The periodic amounts set aside for this purpose are not allowable costs in the period expended, but will be allowed when withdrawn and utilized either through depreciation or expense after considering the usage of these funds. Since the replacement reserves are essentially the same as funded depreciation the same regulations regarding interest will apply.

(2) If a facility is leased from an unrelated party and the ownership of the reserve rests with the lessor, then the replacement reserve payment becomes part of the lease payment and is considered an allowable cost in the year expended. If the lessee is allowed to use this replacement reserve for the replacement of the lessee's assets, lessee shall not be allowed to depreciate the assets purchased.

(e) The provider must maintain appropriate documentation to support the funded depreciation account and income earned thereon to be eligible for relief from the investment income offset.

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 subsection, 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 Subsection 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 subsection 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 subsection 8.7(b), but are subject to the other provisions of subsection 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.

4.12 [Repealed]

4.13 Advertising Expenses

The reasonable and necessary expense of newspaper or other public media advertisement for the purpose of securing necessary employees is an allowable cost. No other advertising expenses are allowed.

4.14 Barber and Beauty Service Costs

The direct costs of barber and beauty services are not allowable for purposes of Medicaid reimbursement. However, the fixed costs for space and equipment related to providing these services and overhead associated with billing for these services are allowable.

4.15 Bad Debt, Charity and Courtesy Allowances

Bad debts, charity and courtesy allowances are deductions from revenues and are not to be included in allowable costs.

4.16 Child Day Care

Reasonable and necessary costs incurred for the provision of day care services to children of employees performing resident related functions will be allowable. Costs will be adjusted by any revenues received for the provision of care provided to employees' children. The direct and indirect expenses related to providing these services to non-employee children are not an allowable expense. Costs must be accumulated in a separate cost center. Revenues earned from providing day care must be identified for employees and non-employees in a separate account.

4.17 Community Service Activities

As an incentive for nursing home providers to furnish needed services (i.e., meals-on-wheels, adult day and certain respite care, etc.) to local communities, with the prior permission of the Division, only direct identifiable incremental costs will be adjusted (i.e., food, direct labor and fringe benefits, transportation). Overhead costs will not be apportioned for adjustment unless there is a significant expansion to a program resulting from community service involvement. The provider must maintain auditable records for all incremental direct costs associated with providing a community service.

4.18 Dental Services

Costs incurred for services performed in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth will not be allowed for the purposes of calculating the per diem rate. Dental services for Medicaid eligible individuals are covered pursuant to the *Medicaid Covered Services Rules*. However, the fixed costs for space and equipment related to providing these services and overhead associated with billing for these services may be allowable.

4.19 Legal Costs

Necessary, ordinary, and reasonable legal fees incurred for resident-related activities will be allowable.

4.20 Litigation and Settlement Costs

(a) Civil and criminal litigation -

(1) General Rule. Attorney fees and other expenses incurred in conjunction with litigation will be recognized only to the extent that the costs are related to resident care, that the provider prevails, and that the costs are not covered by insurance.

(2) Settlements. In instances, where a matter is settled before judgment (whether or not a lawsuit has been commenced), one half the costs, including attorney fees, settlement award, and other expenses, relating to the matter will be recognized to the extent that the costs are related to resident care and are not covered by insurance.

(3) Costs related to criminal or professional practice matters are not allowable.

(b) Challenges to decisions of the Division - Attorney fees and other expenses incurred by a provider in challenging decisions of the Division will be allowed based on the extent to which the provider prevails as determined on the ratio of total dollars at issue in the case to the total dollars awarded to the provider.

(c) All costs recognized pursuant to this subsection shall be subject to the non-recurring costs provision in subsection 4.3(a)(2) or subsection 6.4.

4.21 Motor Vehicle Allowance

Cost of operation of a motor vehicle necessary to meet the facility needs is an allowable cost. Where the vehicle is used for personal and business purposes, the portion of vehicle costs associated with personal use will not be allowed. If the provider does not document personal use and business use under a pre-approved method, DRS reserves the right to disallow all vehicle costs in question. All costs in excess of the cost of a similar size mid-price vehicle are not allowable.

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.

4.23 Compensation of Owners, Operators, or their Relatives

(a) Facilities which have a full-time (40 hours per week minimum) administrator and/or assistant administrator, will not be allowed compensation for owners, operators, or their relatives who claim to provide some or all of the administrative functions required to operate the facility efficiently except in limited and special circumstances such as those listed in paragraph (b) of this subsection.

(b) The factors to be evaluated by the Division in determining the amount allowable for owner's compensation shall include, but not limited to the following:

(1) All applicable Medicare policies identified in CMS-15.

(2) The unduplicated functions actually performed, as described by the provider on the Medicaid cost report.

(3) The hours actually worked and the number of employees supervised, as reported on the cost report.

(c) For any facility fiscal year, the maximum allowable salary for an owner administrator shall be equal to 110 percent of the average of all reported administrator salaries for Vermont nursing facilities participating in the Medicaid program for that facility fiscal year.

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 subsection.

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.

4.26 Post-Retirement Benefits

The allowability of costs of certain benefits which may be available to retired personnel shall be governed by CMS-15, except that all such costs shall be included in fringe benefits and shall be allocated accordingly.

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.

4.28 Related Party

Expenses otherwise allowable shall not be included for purposes of determining a prospective rate where such expenses are paid to a related party unless the provider identifies any such related party and the expenses attributable to it and demonstrates that such expenses do not exceed the lower of the cost to the related party or the price of comparable services, facilities or supplies that could be purchased elsewhere. The Division may request either the provider or the related party, or both, to submit information, books and records relating to such expenses for the purpose of determining their allowability.

4.29 Revenues

Where a facility reports operating and non-operating revenues related to goods or services, the costs to which the revenues correspond are not allowable. If the specific costs cannot be identified, the revenues shall be deducted from the most appropriate costs. If the revenues are more than such costs, the deduction shall be equal to such costs.

4.30 Travel/Entertainment Costs

Only reasonable and necessary costs of meals, lodging, transportation and incidentals incurred for purposes related to resident care will be allowed. All costs determined to be for the pleasure and convenience of the provider or providers' representatives will not be allowed.

4.31 Transportation Costs

(a) Costs of transportation incurred, other than ambulance services for emergency transportation or transportation home from a nursing facility covered pursuant to the *Medicaid Covered Services Rules*, that are necessary and reasonable for the care of residents are allowable. Such costs shall include depreciation of utility vehicles, mileage reimbursement to employees for the use of their vehicles to provide transportation for residents, and any contractual arrangements for providing such transportation. Such costs shall not be separately billed for individual residents.

(b) Transportation costs related to residents receiving kidney dialysis shall be reported in the Ancillary cost category, pursuant to subsection 6.7(a)(5).

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 REIMBURSEMENT STANDARDS

5.1 Prospective Case-Mix Reimbursement System

(a) In general, these rules set out incentives to control costs and Medicaid outlays, while promoting access to services and quality of care.

(b) Case-mix reimbursement takes into account the fact that some residents are more costly to care for than others. Thus the system requires:

(1) the assessment of residents on a form prescribed by the Director of the Division of Licensing and Protection;

(2) a means to classify residents into groups which are similar in costs, known as RUG IV (48 group version) and

(3) a weighting system which quantifies the relative costliness of caring for different classes of residents to determine the average case-mix score.

(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 Subsection 9.2.

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 8 and 10;

(2) in response to a decision by the Secretary pursuant to Subsection 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 Subsection 15.8;

(3) for mechanical computation or typographical errors;

(4) for a terminating facility or a facility in receivership, pursuant to Subsections 5.10, 8.3, and 10.2;

(5) as a result of revised findings resulting from the reopening of a settled cost report pursuant to Subsection 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 subsection 14.1(e)(2) or

(9) when revisions of final rates are necessary to pass the upper limits test in 42 C.F.R. §447.272.

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 subsection, "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).

5.4 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.

5.5 Upper Payment Limits

(a) Aggregate payments to nursing facilities pursuant to these rules may not exceed the limits established for such payment in 42 C.F.R. §447.272.

(b) If the Division projects that Medicaid payments to nursing facilities in the aggregate will exceed the Medicare upper limit, the Division shall adopt a rule limiting some or all of the payments to providers to the level that would reduce the aggregate payments to the Medicare upper limit.

5.6 Base Year

(a) A Base Year shall be a calendar year, January through December.

(b) All costs shall be rebased on July 1, 2007. Subsequent rebasing for Nursing Care costs shall occur two years after the last rebase of such costs. All costs shall be rebased no less frequently than every four years.

(c) For the purposes of rebasing, the Director may require individual facilities to file special cost reports covering the calendar year when this is not the facility's fiscal year or the Division may use the facility's fiscal year cost report adjusted by the inflation factors in subsection 5.8 to the Base Year. The Director may require audited financial statements for the special cost reporting period. The costs of preparing the special cost report and audited financial statements are the responsibility of the provider, without special reimbursement; however, for reporting purposes, these costs are allowable.

(d) The determination of a Base Year shall be subject of a notice of practices and procedures pursuant to Subsection 1.8(d) of these rules.

5.7 Occupancy Level

(a) A facility should maintain an annual average level of occupancy at a minimum of 90 percent of the licensed bed capacity.

(b) For facilities with less than 90 percent occupancy, the number of total resident days at 90 percent of licensed capacity shall be used, pursuant to section 7, in determining the per diem rate for all categories except the Nursing Care and Ancillary categories.

(c) The 90 percent minimum occupancy provision in paragraph (b) shall be waived for facilities with 20 or fewer beds or terminating facilities pursuant to Subsection 5.10, and when appropriate, for facilities operating under a receivership pursuant to Subsection 8.3.

(d) Decreasing the Number of Licensed Beds – For any facility that operated at less than 90 percent occupancy 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.

5.8 Inflation Factors

The Director shall use the most recent publication of the Health Care Cost Service available June 1 in the calculation of inflation factors, whether for rebase inflation calculations or annual inflation calculations. Different inflation factors are used to adjust different rate components. Subcomponents of each inflation factor are weighted in proportion to the percentage of actual allowable costs incurred by Vermont facilities for specific subcomponents of the relevant cost component. For example, if a cost in the Nursing Care cost component is 83.4 percent attributable to salaries and wages and 16.6 percent attributable to employee benefits, the weights for the two subcomponents of the Nursing Care inflation factor shall be 0.834 and 0.166 respectively. The weights for each inflation factor shall be recalculated no less frequently than each time the relevant cost category is rebased.

(a) The Nursing Care rate component shall be adjusted by an inflation factor that uses two price indexes to account for estimated economic trends with respect to two subcomponents of nursing costs: wages and salaries, and benefits. The price indexes for each subcomponent are the wages and salaries portion of the Health-Care Cost Service NHMB, and the employee benefits portion of the NHMB, respectively. An additional adjustment of one percentage point shall be made for every 12 month period, prorated for fractions thereof, from the midpoint of the base year to the midpoint of the rate year.

(b) The Resident Care Rate Component shall be adjusted by an inflation factor that uses four price indexes to account for estimated economic trends with respect to the subcomponents of Resident Care costs: wages and salaries, employee benefits, utilities, and food and all other Resident care costs. The price indexes for each subcomponent are: the wages and salaries portion of the Health-Care Cost Service NHMB, the employee benefits portion of the NHMB, the utilities portion of the NHMB, and the food portion of the NHMB respectively.

(c) The Indirect rate component shall be adjusted by an inflation factor that uses three price indexes to account for estimated economic trends with respect to three subcomponents of Indirect costs: wages and salaries, employee benefits, and all other indirect costs. The price indexes for each subcomponent are: the wages and salaries portion of the Health-Care Cost Service NHMB, the employee benefits portion of the NHMB and the NECPI-U (all items), respectively.

(d) The Director of Nursing rate component shall be adjusted by an inflation factor that uses two price indexes to account for estimated economic trends with respect to two subcomponents of Director of Nursing costs: wages and salaries and employee benefits. The price indexes for each subcomponent are: the wages and salaries portion of the Health-Care Cost Service NHMB, and the employee benefits portion of the NHMB, respectively.

(e) Pursuant to Subsection 1.8(d), the Division shall issue a description of the practices and procedures used to calculate and apply the Inflation Factors.

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 90 percent occupancy 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 4 and 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 subsection 3.2 for its first full fiscal year of operation.

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 subsection 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 subsection 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 Subsection 5.7, the limitations on costs in Section 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 subsection shall remain in effect for a period not to exceed six months.

6 BASE YEAR COST CATEGORIES FOR NURSING FACILITIES

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:

6.2 Nursing Care Costs

(a) Allowable costs for the Nursing Care component of the rate shall include actual costs of licensed personnel providing direct resident care, which are required to meet federal and state laws as follows:

(1) registered nurses,
(2) licensed practical nurses,
(3) certified or licensed nurse aides, including wages related to initial and on-going nurse aide training as required by OBRA,
(4) contract nursing,
(5) the MDS coordinator,
(6) fringe benefits, including child day care.

(b) Costs of bedmakers, geriatric aides, transportation aides, paid feeding/dining assistants, ward clerks, medical records librarians and other unlicensed staff will not be considered nursing costs. The salary and related benefits of the position of Director of Nursing shall be excluded from the calculation of allowable nursing costs and shall be reimbursed separately.

6.3 Resident Care Costs

Allowable costs for the Resident Care component of the rate shall include reasonable costs associated with expenses related to direct care. The following are Resident Care costs:

(a) food, vitamins and food supplements,
(b) utilities, including heat, electricity, sewer and water, garbage and liquid propane gas,
(c) activities personnel, including recreational therapy and direct activity supplies,
(d) Medical Director, Pharmacy Consultant, Geriatric Consultant, and Psychological/psychiatric Consultant,
(e) counseling personnel, chaplains, art therapists and volunteer stipends,
(f) social service worker,
(g) employee physicals,
(h) wages for paid feeding/dining assistants only for those hours that they are actually engaged in assisting residents with eating,
(i) fringe benefits, including child day care,
(j) such other items as the Director may prescribe by a practice and procedure issued pursuant to subsection 1.8(d).

6.4 Indirect Costs

(a) Allowable costs for the indirect component of the rate shall include costs reported in the following functional cost centers on the facility's cost report, including those extracted from a facility's cost report or the cost report of an affiliated hospital or institution.

(1) fiscal services,
(2) administrative services and professional fees,
(3) plant operation and maintenance,
(4) grounds,
(5) security,
(6) laundry and linen,
(7) housekeeping,
(8) medical records,
(9) cafeteria,
(10) seminars, conferences and other in-service training (except tuition for college credit in a discipline related to the individual staff member's employment or costs of obtaining a GED which shall be treated as fringe benefits),
(11) dietary excluding food,
(12) motor vehicle,
(13) clerical, including ward clerks,
(14) transportation (excluding depreciation),
(15) insurances (director and officer liability, comprehensive liability, bond indemnity, malpractice, premise liability, motor vehicle, and any other costs of insurance incurred or required in the care of residents that has not been specifically addressed elsewhere),
(16) office supplies/telephone,
(17) conventions and meetings,
(18) EDP bookkeeping/payroll,
(19) fringe benefits including child day care.

(b) All expenses not specified for inclusion in another cost category pursuant to these rules shall be included in the Indirect Costs category, unless the Director at her/his discretion specifies otherwise in the instructions to the cost report, the chart of accounts, or by the issuance of a practice and procedure. For nursing facility rate setting, the costs of prescription drugs are not allowable.

6.5 Director of Nursing

Allowable costs associated with the position of Director of Nursing shall include reasonable salary for one position and associated fringe benefits, including child day care.

6.6 Property and Related

(a) The following are Property and Related costs:

(1) depreciation on buildings and fixed equipment, major movable equipment, minor equipment, computers, motor vehicle, land improvements, and

amortization of leasehold improvements and capital leases,
(2) interest on capital indebtedness,
(3) real estate leases and rents,
(4) real estate/property taxes,
(5) all equipment irrespective of whether it is capitalized, expensed, or rented,
(6) fire and casualty insurance,
(7) amortization of mortgage acquisition costs.

(b) For a change in services, facility, or a new health care project with projected property and related costs of $250,000 or more, providers shall give written notice to the Division no less than 60 days before the commencement of the project. Such notice shall include a detailed description of the project and detailed estimates of the costs.

6.7 Ancillaries

(a) The following are ancillary costs:

(1) All physical, speech, occupational, respiratory, and IV therapy services and therapy supplies (excluding oxygen) shall be considered ancillaries. Medicaid allowable costs shall be based on the cost-to-charge ratio for these services. These therapy services shall not be allowable for Medicaid reimbursement pursuant to this subsection unless:

(i) the services are provided pursuant to a physician's order,

(ii) the services are provided by a licensed therapist or other State certified or registered therapy assistant, or qualified IV professional, or other therapy aides,

(iii) the services are not reimbursable by the Medicare program, and

(iv) the provider records charges by payor class for all units of these services.

(2) Medical supplies, whether or not the provider customarily records charges.

(i) Medical supplies shall include, but are not limited to: oxygen, disposable catheters, catheters, colostomy bags, drainage equipment, trays and tubing.

(ii) Medical supplies shall not include rented or purchased equipment, with the exception of rented or purchased oxygen concentrators, which shall be included in medical supplies.

(3) Over-the-counter drugs. All drug costs may be disallowed for providers commingling the costs of prescription drugs (which are not allowable) and over-the-counter drugs.

(4) Incontinent Supplies and Personal Care Items: including adult diapers, chux and other disposable pads, personal care items, such as toothpaste, shampoo, body powder, combs, brushes, etc.

(5) Dialysis Transportation. The costs of transportation for Medicaid residents receiving kidney dialysis shall be included in the ancillary cost category. Allowable costs may include contract or other costs, but shall not include employee salaries or wages or cost associated with the use of provider-owned vehicles.

(6) Overhead costs related to ancillary services and supplies are included in ancillary costs.

(b) [Repealed]

7 CALCULATION OF COSTS, LIMITS AND RATE COMPONENTS FOR NURSING FACILITIES

Base year costs, rates, and category limits are calculated pursuant to this section. The Medicaid per diem payment rate for each facility is calculated pursuant to Section 9.

7.1 Calculation of Per Diem Costs

Per diem costs for each cost category, excluding the Nursing Care and Ancillary

cost categories, are calculated by dividing allowable costs for each case-mix category by the greater of actual bed days of service rendered, including revenue generating hold/reserve days, or the number of resident days computed using the minimum occupancy at 90 percent of the licensed bed capacity during the cost period under review calculated pursuant to subsection 5.7.

7.2 Nursing Care Component

(a) Case-Mix Weights.

There are 48 case-mix resident classes. Each case-mix class has a specific case-mix weight as follows:

Group Code	Case-Mix Weight	Description
ES3	3.00	Extensive Services
ES2	2.23	Extensive Services
ES1	2.22	Extensive Services
RAE	1.65	Rehabilitation
RAD	1.58	Rehabilitation
RAC	1.36	Rehabilitation
RAB	1.10	Rehabilitation
RAA	0.82	Rehabilitation
HE2	1.88	Special Care High
HE1	1.47	Special Care High
HD2	1.69	Special Care High
HD1	1.33	Special Care High
HC2	1.57	Special Care High
HC1	1.23	Special Care High
HB2	1.55	Special Care High
HB1	1.22	Special Care High
LE2	1.61	Special Care Low
LE1	1.26	Special Care Low
LD2	1.54	Special Care Low
LD1	1.21	Special Care Low
LC2	1.30	Special Care Low
LC1	1.02	Special Care Low
LB2	1.21	Special Care Low
LB1	0.95	Special Care Low
CE2	1.39	Clinically Complex
CE1	1.25	Clinically Complex
CD2	1.29	Clinically Complex
CD1	1.15	Clinically Complex
CC2	1.08	Clinically Complex
CC1	0.96	Clinically Complex
CB2	0.95	Clinically Complex
CB1	0.85	Clinically Complex
CA2	0.73	Clinically Complex
CA1	0.65	Clinically Complex
BB2	0.81	Behavioral Symptoms Plus Cognitive Performance
BB1	0.75	Behavioral Symptoms Plus Cognitive Performance
BA2	0.58	Behavioral Symptoms Plus Cognitive Performance
BA1	0.53	Behavioral Symptoms Plus Cognitive Performance
PE2	1.25	Reduced Physical Function
PE1	1.17	Reduced Physical Function
PD2	1.15	Reduced Physical Function
PD1	1.06	Reduced Physical Function
PC2	0.91	Reduced Physical Function
PC1	0.85	Reduced Physical Function
PB2	0.70	Reduced Physical Function
PB1	0.65	Reduced Physical Function
PA2	0.49	Reduced Physical Function
PA1	0.45	Reduced Physical Function

(b) Average case-mix score

The Department of Disabilities, Aging and Independent Living's Division of Licensing and Protection shall compute each facility's average case-mix score.

(1) The Division of Licensing and Protection shall periodically, but no less frequently than quarterly, certify to the Division of Rate Setting the average case-mix score for those residents of each facility whose room and board (excluding resident share) is paid for solely by the Medicaid program.

(2) For the Base Year, the Division of Licensing and Protection shall certify the average case-mix score for all residents.

(c) Nursing Care cost per case-mix point. Each facility's Nursing Care cost per case-mix point will be calculated as follows:

(1) Using each facility's Base Year cost report, the total allowable Nursing Care costs shall be determined in accordance with Subsection 6.2.

(2) Each facility's Standardized Resident Days shall be computed by multiplying total Base Year resident days by that facility's average case-mix score for all residents for the four quarters of the cost reporting period under review.

(3) The per diem nursing care cost per case-mix point shall be computed by dividing total Nursing Care costs by the Base Year Standardized Resident Days for that Base Year.

(d) Per diem limits on the Base Year allowable Nursing Care rate per case-mix point:

(1) The Division shall array all nursing care facilities' allowable Base Year per diem Nursing Care costs per case-mix point, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high. These costs shall be limited to the cost at the ninetieth percentile, calculated using the percentile spreadsheet function.

(2) Each facility's Base Year Nursing Care rate per case-mix point shall be the lesser of the limit in subparagraph (1) or the facility's allowable Nursing Care cost per case-mix point.

7.3 Resident Care Base Year Rate

Resident Care Base Year rates shall be computed as follows:

(a) Using each facility's Base Year cost report, the provider's Base Year total allowable Resident Care costs shall be determined in accordance with Subsection 6.3.

(b) The Base Year per diem allowable Resident Care costs for each facility shall be calculated by dividing the Base Year total allowable Resident Care costs by total Base Year resident days.

(c) The Division shall array all nursing facilities' Base Year per diem allowable Resident Care costs, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high and identify the median.

(d) The per diem limit shall be the median plus five percent.

(e) Each facility's Base Year Resident Care per diem rate shall be the lesser of the limit set in paragraph (d) or the facility's Base Year per diem allowable Resident Care costs.

7.4 Indirect Base Year Rate

Indirect Base Year rates shall be computed as follows:

(a) Using each facility's Base Year cost report, each provider's Base Year total allowable Indirect costs shall be determined in accordance with Subsection 6.4.

(b) The Base Year per diem allowable Indirect costs for each facility shall be calculated by dividing the Base Year total allowable Indirect costs by total Base Year resident days.

(c) The Division shall array all nursing facilities' Base Year per diem allowable Indirect costs, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high and identify the median.

(d) The per diem limit shall be set as follows:

(1) For special hospital-based nursing facilities, the limit shall be 137 percent of the median.

(2) For all other privately-owned nursing facilities, the limit shall be the median plus five percent.

(e) Each provider's Base Year Indirect per diem rate shall be the lesser of the limit in paragraph (d) or the facility's Base Year per diem allowable Indirect costs.

7.5 Director of Nursing Base Year Rate

The Director of Nursing Base Year per diem rates shall be computed as follows:

(a) Using each facility's Base Year cost report, total allowable Base Year Director of Nursing costs shall be determined in accordance with Subsection 6.5.

(b) Each facility's Base Year per diem allowable Director of Nursing costs shall be calculated by dividing the Base Year total allowable Director of Nursing costs by total Base Year resident days.

(c) The Director of Nursing per diem rate shall be the facility's Base Year per diem allowable Director of Nursing costs calculated pursuant to this subsection.

7.6 Ancillary Services Rate

(a) The Ancillary per diem rate shall be computed as follows:

(1) Medicaid Ancillary costs shall be determined in accordance with subsection 6.7.

(2) Using each facility's most recently settled cost report, the per diem Ancillary rate shall be the sum of the following per diem costs calculated as follows:

(i) Costs for therapy services per diem, including IV therapy, shall be calculated by dividing allowable Medicaid costs by the number of related Medicaid resident days less Medicaid hold days.

(ii) Dialysis transportation costs per diem shall be calculated by dividing the allowable costs for Vermont Medicaid residents by the number of Vermont Medicaid resident days less Vermont Medicaid hold days.

(iii) Costs for medical supplies, over-the-counter drugs, and incontinent supplies and personal care items per diem shall be calculated by dividing allowable costs, by total resident days less hold days.

(b) Any change to the Ancillary per diem rate shall be implemented at the time of the first quarterly case-mix rate recalculation after the cost report is settled.

7.7 Property and Related Per Diem

The Property and Related per diem rate shall be computed as follows:

(a) Using each facility's most recently settled annual cost report, total allowable Property and Related costs shall be determined in accordance with Subsection 6.6.

(b) Using each facility's most recently settled cost report, the per diem property and related costs shall be calculated by dividing allowable property and related costs by total resident days. Any change to the property and related per diem rate shall be implemented at the time of the first quarterly case-mix rate recalculation after the cost report is settled.

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, the limits set pursuant to subsections 7.2(d)(2), 7.3(d), and 7.4(d) 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.

8 ADJUSTMENTS TO RATES

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.

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.

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.

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.

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 subsection for a period of up to two years.

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.

8.7 Procedures and Requirements for Rate Adjustments

(a) Application for a rate adjustment pursuant to this section should be made as follows. Approval of any application for a rate adjustment under this section is at the sole discretion of the Director.

(b) Except for applications made pursuant to subsection 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.

(c) 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 proofs 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. Principles and decisions of general applicability shall be issued as a Division practice or procedure, pursuant to Section 1.8(d).

(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, or, at the discretion of the Division, the first day of the quarter immediately preceding the final order 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 subsection 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 subsection 5.9. Appropriate cases may include, but are not limited to, changes in the number of beds, an addition to the facility, or the replacement of existing property.

(k) In calculating an adjustment under this section and subsection 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 subsection 4.11 based on a "look-back" which will be computed based on a provider's actual allowable costs.

(m) In this subsection "additional costs" means the incremental costs of providing resident care directly and proximately caused by one of the events listed in this section or subsection 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.

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.

9 PRIVATE NURSING FACILITY AND STATE NURSING FACILITY RATES

The Medicaid per diem payment rates for nursing home services are calculated according to this section as follows:

9.1 Nursing Facility Rate Components

The per diem rate of reimbursement consists of the following rate components:

(a) Nursing Care
(b) Resident Care
(c) Indirect
(d) Director of Nursing
(e) Property and Related
(f) Ancillaries
(g) Adjustments (if any)

9.2 Calculation of the Total Rate

The total per diem rate in effect for any nursing facility shall be the sum of the rates calculated for the components listed in Subsection 9.1, adjusted in accordance with the Inflation Factors, as described in Subsection 5.8.

9.3 Updating Rates for a Change in the Average Case-Mix Score

(a) The Nursing Care rate component shall be updated quarterly, on the first day of January, April, July and October, for changes in the average case-mix score of the facility's Medicaid residents.

(b) The Nursing Care rate component and any part of a Section 8 adjustment that reimburses nursing costs are updated for a change in the average case-mix score for the facility's Medicaid residents. The update is calculated as follows:

(1) The Nursing Care rate component (or rate adjustment) in the current rate of reimbursement for a facility is divided by the average case-mix score used to determine the current Nursing Care rate component. This quotient is the current Nursing Care rate per case-mix point.

(2) The current Nursing Care rate component (or rate adjustment) per case-mix point is multiplied by the new average case-mix score. This product is the new Nursing Care rate component (or rate adjustment).

(c) the Division may use an average of the case-mix scores from the two most recent available quarters having complete case-mix score data if nursing facilities are temporarily exempt from any part of the standard minimum data set (MDS) reporting requirements by CMS as a result of the National Health Emergency declared in response to the COVID-19 pandemic and do not submit updated or complete MDS data to the Department of Disabilities, Aging and Independent Living.

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 3 and 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.

(d) At no time shall the final rates paid to State nursing facilities exceed the upper limits established in 42 C.F.R. §447.272.

9.5 Quality Incentives

Certain awards shall be made annually to facilities that provide a superior quality of care in an efficient and effective manner.

(a) These payments will be based on:

(1) objective standards of quality, which shall include resident satisfaction surveys, to be determined by the Department of Disabilities, Aging and Independent Living, and

(2) objective standards of cost efficiency determined by the Division.

(b) Supplemental payments will not be available under this subsection for any facility that does not participate in the statewide resident satisfaction survey program.

(c) Supplemental payments shall be expended by the provider to enhance the quality of care provided to Medicaid eligible residents. In determining the nature of these expenditures, the provider shall consult with the facility's Resident Council.

(d) The amount and method of distribution of the quality incentive payments shall be as follows:

(1) The quality incentive payments shall be made from a pool. The annual size of the pool shall be based on the amount of $25,000 times the number of facilities meeting the award criteria, up to a maximum of five.

(2) The pool shall be distributed among the qualifying facilities, awarding each qualifying facility a share of the pool based on the ratio of its Medicaid days to the total Medicaid days for all the qualifying facilities.

(e) Award Criteria

The following criteria will be applied to facility data up to March 31 each year to determine eligibility for the award to be presented in May. In order to be eligible for the award, a facility must participate in the Vermont Medicaid program and meet all of the following criteria. All eligible facilities will be ranked according to their quality of care by the Department of Disabilities, Aging and Independent Living based on these basic quality criteria. The five facilities with the highest quality of care will receive an award. If, based on the basic criteria, there are ties which would cause more than five facilities to be equally qualified, the tied facilities will be ranked according to the efficiency criteria set out below in paragraph (6), to determine those facilities that will receive an award.

(1) The most recent health survey report resulted in a score of five or less, no deficiency with a scope and severity greater than "D" level, with no more than two "D" level deficiencies in the general categories of Quality of Care, Quality of Life, or Resident Rights.

(2) No substantiated complaints since the most recent survey and prior full health survey related to quality of care, quality of life, or residents' rights.

(3) Participation in Advancing Excellence in America's Nursing Homes campaign.

(4) Resident satisfaction survey results above the statewide average.

(5) Fire Safety deficiency score of 5 or less with scope and severity less than "E" in the most recent full survey.

(6) The efficiency rankings shall be based upon the allowable costs per day from each facility's most recently settled Medicaid cost report. Cost per day will be calculated using actual resident days for the same fiscal period.

10 EXTRAORDINARY FINANCIAL RELIEF

10.1 Objective

In order to protect Medicaid recipients from the closing of a nursing facility in which they reside and to provide financial relief to nursing facilities in response to the State of Emergency declared by the Governor of the State of Vermont on March 13, 2020 related to the COVID-19 outbreak, this section establishes a process by which nursing facilities that are in immediate danger of failure or that are experiencing unexpected financial burdens related to COVID-19 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.

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 Commissioner of the Department of Vermont Health Access 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 Commissioner. The interim financial relief shall be taken into account in the Division's Recommendation to the Commissioner and in the Commissioner's Final Decision.

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 or that the relief sought is a result of unexpected costs associated with the COVID-19 State of Emergency.

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

(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.

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~~ Commissioner 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.

11 PAYMENT FOR OUT-OF-STATE PROVIDERS

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.

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.

(b) 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 Subsection 11.1.

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.

12 RATES FOR ICF/MRS

12.1 Reasonable Cost Reimbursement

Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are paid according to Medicaid principles of reimbursement,

pursuant to the *Regulations Governing the Operation of Intermediate Care Facilities for the Mentally Retarded* adopted by the Agency.

12.2 Application of these Rules to ICF/MRS

The Division's Accounting Requirements (Section 2) and Financial Reporting (Section 3) shall apply to this program.

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 14 and subsection 9.5 shall not be included in the calculation of swing-bed rates.

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 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 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 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 other similarly situated individuals as the Commissioner of Mental Health shall approve. The rate shall be prospective and shall be set before admission of the individual to the facility.

(1) The special rate payable for each individual shall consist of the current per diem rate for the receiving facility as calculated pursuant to Sections 5 to 9 of these rules and a monthly supplemental incentive payment. Three levels of supplemental payments are available for the care of residents meeting the eligibility criteria in this subsection based on the severity of the resident's condition and the resources needed to provide care.

(2) The supplemental payment will continue to be paid as long as the criteria in paragraph (c) are satisfied.

(b) To be eligible for a special rate, the receiving facility must have in place a plan of care developed in conjunction with and approved by the Commissioner of Mental Health and the Division of Licensing and Protection.

(c) Criteria for continuation of supplemental payments:

(i) The transferred person continues to reside at the receiving facility.

(ii) The facility documents to the satisfaction of the Division of Licensing and Protection that the transferred person continues to present significant behavior management problems by exhibiting behaviors that are significantly more challenging than those of the general nursing facility population.

(d) Any advance payments for days during which the transferred person is not resident or ceases to be eligible for the special transitional rate will be treated as overpayments and subject to refund by deductions from the provider's Medicaid payments.

14.3 Special Rates for Medicaid Eligible Furloughees of the Department of Corrections

A special rate equal to 150 percent of a nursing facility's ordinary Medicaid rate shall be paid for care provided to Medicaid eligible furloughees of the Department of Corrections.

15 ADMINISTRATIVE REVIEW AND APPEALS

15.1 Draft Findings and Decisions

(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.

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 Subsection 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 Subsection 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 Subsection 15.2(a), the Division's draft findings and/or decision are final and no longer subject to administrative review or judicial appeal.

15.3 Request for Reconsideration

(a) A provider that is aggrieved by an official action issued pursuant to Subsection 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 subsection 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.

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 Subsections 15.5, 15.6 and 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.

(i) 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.

(ii) 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.

(2) 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.

(i) 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.

(ii) 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.

(iii) 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.

(3) Further review of the Final Determination is available only pursuant to

Rule 75 of the Vermont Rules of Civil Procedure.

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) A party aggrieved by a Final Determination of the Secretary may obtain judicial review pursuant to 33 V.S.A. §909(a)(1) and (2) and Subsections 15.6 and 15.7 of this Rule.

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.

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.

15.8 Settlement Agreements

The Director may agree to settle reviews and appeals taken pursuant to Subsections 15.3 and 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.

16 DEFINITIONS AND TERMS

For the purposes of these rules the following definitions and terms are used:

Accrual Basis of Accounting: 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.

Agency: the Agency of Human Services.

AICPA: American Institute of Certified Public Accountants.

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

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

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

Centers for Medicare and Medicaid Services(CMS) (formerly called the Health Care Financing Administration (HCFA)): Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.

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, 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.

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

Notwithstanding any other provisions of these rules, the amendments to these rules effective March 6, 2015 shall be applied to payments for services rendered on or after March 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 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.

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.

(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. 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

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

~~MARCH 2015~~

Emergency Rule
April 2020
{Additions to the existing rule are underlined and removals ~~stricken~~.}

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1 GENERAL PROVISIONS

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).

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, and Intermediate Care Facilities for the Mentally Retarded are reimbursed under different methods and standards. Swing-bed hospitals are reimbursed pursuant to 42 U.S.C. §1396l(b)(1). Intermediate Care Facilities for the Mentally Retarded are reimbursed pursuant to the *Regulations Governing the Operation of Intermediate Care Facilities for the Mentally Retarded* adopted by the Agency and are subject to the Division's Accounting Requirements (Section 2) and Financial Reporting (Section 3).

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).

1.4 General Description of the Rate Setting System

A prospective case-mix payment system for nursing facilities is established by these rules 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.

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 Subsection 1.5(a).

1.6 Responsibilities of Owners

The owner of a nursing facility shall prudently manage and operate a residential health care program of adequate quality to meet its residents' needs. Neither the issuance of a per diem rate, nor final orders made by the Director or a duly authorized representative shall in any way relieve the owner of a nursing facility from full responsibility for compliance with the requirements and standards of the Agency of Human Services.

1.7 Duties of the Owner

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

(a) Comply with the provisions of Subsections 1.5 and 1.6 setting forth the requirements for participation in the Medicaid Program.

(b) Submit cost reports in accordance with the provisions of subsections 3.2 and 3.3 of these rules.

(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 subsection 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.

1.8 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 or related party or organization to file such relevant and appropriate data, statistics, schedules or information as the Division finds necessary to enable it to carry out its function.

(c) The Division may examine books and accounts of any nursing facility and related parties 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) Copies of each notice of practice and procedure, form, or set of instructions shall be sent to each nursing facility participating in the Medicaid program at the time it is issued. A compilation of all such documents currently in force shall be maintained at the Division, pursuant to 3 V.S.A. §835, and shall be available to the public.

(g) Neither the issuance of final per diem rates nor Final Orders of the Division which fail, in any one or more instances, to enforce the performance of any of the terms or conditions of these rules shall be construed as

a waiver of the Division's future performance of the right. The obligations of the provider with respect to performance shall continue, and the Division shall not be estopped from requiring such future performance.

1.9 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 upon the federal RUG IV classification system (48 group version). 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.

1.10 Computation of and Enlargement of Time; Filing and Service of Documents

(a) In computing any period of time prescribed or allowed by these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a state or federal legal holiday, in which event the period runs until the end of the next day which is not a Saturday, a Sunday, or a state or federal legal holiday.

(b) For the purposes of any provision of these rules in which time is computed from the receipt of a notice or other document issued by the Division or other relevant administrative officer, the addressee of the notice shall be rebuttably presumed to have received the notice or other document three days after the date on the document.

(c) When by these rules or by a notice given thereunder, an act is required or allowed to be done at or within a specified time, the relevant administrative officer, for just cause shown, may at any time in her or his discretion, with or without motion or notice, order the period enlarged. This subsection 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.

(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, October 29, 2007, August 25, 2008, April 1, 2011, September 17, 2012, September 9, 2013, and March 6, 2015).

(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 reports and the non-accrual fiscal accounts.

The provider shall retain all such documentation for audit purposes.

2.2 Procurement Standards

(a) Providers shall establish and maintain a code of standards to govern the performance of its employees engaged in purchasing goods and services. Such standards shall provide, to the maximum extent practical, open and free competition among vendors. Providers should participate in group purchasing plans when feasible.

(b) If a provider pays more than a competitive bid for a good or service, any amount over the lower bid which cannot be demonstrated to be a reasonable and necessary expenditure that satisfies the prudent buyer principle is a nonallowable cost.

2.3 Cost Allocation Plans and Changes in Accounting Principles

With respect to the allocation of costs to the nursing facility and within the nursing facility, the following rules shall apply:

(a) [Repealed]

(b) Providers that have costs allocated from related entities included in their cost reports shall include, as a part of their cost report submission, a summary of the allocated costs, including a reconciliation of the allocated costs to the entity's financial statements, which must also be submitted with the Medicaid cost report. In the case of a home office or related management company, this would include a completed Home Office Cost Statement. The provider shall submit this reconciliation with the Medicaid cost report.

(c) The Division reserves the right not to recognize changes in accounting principles or methods or basis of cost allocation made for the purpose or having the likely effect of increasing a facility's Medicaid payments.

(d) [Repealed]

(e) [Repealed]

(f) Each provider shall notify the Division of changes in statistical allocations or record keeping required by the Medicare Intermediary.

(g) Preferred statistical methods of allocation are as follows:

(1) Nursing salaries and supplies - direct cost,

(2) Plant operations - square footage,

(3) Utilities - square footage,

(4) Laundry - pounds of laundry,

(5) Dietary -resident days,

(6) Administrative and General - accumulated costs,

(7) [Repealed]

(8) Property and Related - square footage,

(9) Fringe Benefits - direct allocation/gross salaries.

(h) Food costs included in allocated dietary costs are calculated by dividing the facility's allocated dietary costs by total organization dietary costs, both of which include allocated overhead, and multiplying the result by the total organization food costs.

(i) Utility costs included in allocated plant operation and maintenance costs are calculated by dividing the facility's plant operation and maintenance costs by total organization plant operation and maintenance cost, both of which include allocated overhead, and multiplying the result by the total organization utility costs.

(j) All administrative and general costs, including home office and management

company costs, allocated to a facility shall be included in the Indirect Cost category.

(k) The capital component of goods or services purchased or allocated from a related or unrelated party, such as plant operation and maintenance, utilities, dietary, laundry, housekeeping, and all others, whether or not acquired from a related party, shall be considered as costs for that particular good or service and not classified as Property and Related costs of the nursing facility.

(l) Costs allocated to the nursing facility shall be reasonable, as determined by the Division pursuant to these rules.

2.4 Substance Over Form

The cost effect of transactions that have the effect of circumventing the intention of these rules may be adjusted by the Division on the principle that the substance of the transaction shall prevail over the form.

2.5 Record Keeping and Retention of Records

(a) Each provider must maintain complete documentation, including accurate financial and statistical records, to substantiate the data reported on the uniform financial and statistical report (cost report), and must, upon request, make these records available to the Division of Rate Setting, or the U. S. Department of Health and Human Services, and the authorized representatives of both agencies.

(b) 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.

(c) 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.

(d) 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. With the exception of the administrator's salary, the salaries and wages of individual employees shall not be made public.

3 FINANCIAL REPORTING

3.1 [Repealed]

3.2 Uniform Cost Reports

(a) Each long-term care facility participating in the Vermont Medicaid program shall annually submit a uniform financial and statistical report (cost report) on forms prescribed by the Division. The inclusive dates of the reporting year shall be the 12

month period of each provider's fiscal year, unless advance authorization to submit a report for a greater or lesser period has been granted by the Division.

(1) The Division may require providers to file special cost reports for periods other than a facility's fiscal year.

(2) The Division may require providers to file budget cost reports. Such cost reports may be used inter alia as the basis for new facilities' rates or for rate adjustments.

(b) The cost report must include the certification page signed by the owner, or its representative, if authorized in writing by the owner.

(c) The original and one copy of the cost report must be submitted to the Division. All documents must bear original signatures.

(d) The following supporting documentation is required to be submitted with the cost report:

(1) Audited financial statements (except that at the discretion of the Director, this requirement may be waived),

(2) Most recently filed Medicare Cost Report with the required supplemental data on CMS Form 339 (if a participant in the Medicare Program), which for hospital-based nursing homes shall be the Medicare cost report for the same fiscal year as the Medicaid cost report,

(3) Independent auditor's adjusting entries and reconciliation of the audited financial statements to the cost report.

(e) A provider must also submit, upon request during the desk review or audit process, such data, statistics, schedules or other information which the Division requires in order to carry out its function. If, before the draft findings are issued, the facility has been specifically requested to provide certain information or materials and has failed to do so, such information or materials will not be admissible in any subsequent appeal taken pursuant to Section 15, provided the Division has notified the provider of such failure and afforded the provider a final opportunity to cure.

(f) Providers shall follow the cost report instructions prescribed by the Director in completing the cost report. The chart of accounts prescribed by the Director, shall be used as a guideline providing the titles, and description for type of transactions recorded in each asset, liability, equity, income, and expense account.

3.3 Adequacy and Timeliness of Filing

(a) With the exception of hospital-based nursing homes, an acceptable cost report filing shall be made on or before the last day of the fifth month following the close of the period covered by the report.

(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.

(b) The Division may reject any filing which does not comply with these regulations and/or the cost reporting instructions. In such case, the report shall be deemed not filed, until refiled and in compliance.

(c) Extensions for filing of the cost report beyond the prescribed deadline must be requested as follows:

(1) All Requests for Extension of Time to File Cost Report must be in writing, on a form prescribed by the Director, and must be received by the Division of Rate Setting prior to the due date. The provider must

clearly explain the reason for the request and specify the date on which the Division will receive the report.

(2) Notwithstanding any previous practice, the Division will not grant automatic extensions. Such extensions will be granted for good cause only, at the Director's sole discretion, based on the merits of each request. A "good cause" is one that supplies a substantial reason, one that affords a legal excuse for the delay or an intervening action beyond the provider's control. The following are not considered "good cause": ignorance of the rule, inconvenience, or a cost report preparer engaged in other work.

(d) Notwithstanding any other provision of these rules, any provider that fails to make a complete cost report filing within the time prescribed in subsection 3.3(a) or within an extension of time approved by the Division, shall be subject to the provisions of subsection 1.7(f).

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.

(c) The procedure for issuing and reviewing Summaries of Findings is set out in Subsections 15.1, 15.2 and 15.3.

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 Subsection 15.3 of these rules.

(b) Cost report determinations and decisions, otherwise final, may be reopened and corrected when the specific requirements set out below are met. The Division's decision to reopen will be based on new and material evidence submitted by the provider, evidence of a clear and obvious material error, or a determination by the Secretary or a court of competent jurisdiction that the determination is inconsistent with applicable law, regulations and rulings, or general instructions.

(c) Reopening means an affirmative action taken by the Division to re-examine the correctness of a determination or decision otherwise final. Such action may be taken:

(1) On the initiative of appropriate authority within the applicable time period set out in paragraph (f), or

(2) In response to a written request of the provider or other relevant entity, filed with the Division within the applicable time period set out in subsection (f), and

(3) When the reopening has a material effect (more than one percent) on the provider's Medicaid rate payments.

(d) A correction is a revision (adjustment) in the Division's determination or Secretary's decision, otherwise final, which is made after a proper re-opening.

(e) A correction may be made by the Division, or the provider may be required to file an amended cost report. If the cost report is reopened by an order of the Secretary or a court of competent jurisdiction, the correction shall be made by the Division.

(f) A determination or decision may be reopened within three years from the date of the notice containing the Division's determination, or the date of a decision by the Secretary or a court.

(g) The Division may also require or allow an amended cost report to correct material errors detected subsequent to the filing of the original cost report or to comply with applicable standards and regulations. Once a cost report is filed, the provider is bound by its elections. The Division shall not accept an amended cost report to avail the provider of an option it did not originally elect.

4 DETERMINATION OF ALLOWABLE COSTS FOR NURSING FACILITIES

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, 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 regulations 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 subsection.

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.

4.3 Non-Recurring Costs

(a) Non-recurring costs shall include:

(1) any reasonable and resident-related cost that exceeds $10,000, which is not expected to recur on an annual basis in the ordinary operation of the facility, may be designated by the Division as a "Non-Recurring Cost" subject to any limits on the cost category into which the type of cost would otherwise be assigned,

(2) litigation expenses of $10,000 or more, recognized pursuant to subsection 4.20.

(3) allowable lump-sum costs of $2,000 or more per cost reporting period for recruitment and legal fees or similar expenses associated with the hiring of registered nurses from countries outside the United States on condition that such fees or expenses shall be allowable only in respect of such nurses who are paid at least the prevailing salary/wage and benefits for employed nurses of similar qualifications and experience in the geographic area in which the facility is located or tuition expenses for nurse aide training reimbursed pursuant to 42 C.F.R. §483.152(c)(2).

(b) A non-recurring cost 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.

4.4 Interest Expense

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

(b) “Necessary requires that:

(1) The interest be incurred on a loan made to satisfy a financial need of the provider.

(2) A financial need does not exist if the provider has cash and/or cash equivalents of more than 60 days cash needs.

(3) Cash and cash equivalents include:

(i) monetary investments, including unrestricted grants and gifts,

(ii) non-monetary investments not related to resident care that can readily be converted to cash net of any related liability,

(iii) receivables from (net of any payables to) officers, owners, partners, parent organizations, brother/sister organizations, or other related parties, excluding education loans to employees.

(iv) receivables that result from transactions not related to resident care.

(4) Cash and cash equivalents exclude:

(i) funded depreciation recognized by the Division,

(ii) restricted grants and gifts.

(5) Interest income offset.

(i) Interest expense shall be reduced by realized investment income, except where such income is from:

(A) funded depreciation recognized by the Division pursuant to CMS-15,

(B) grants and gifts, whether restricted or unrestricted.

(ii) Only working capital interest expense shall be offset by interest income derived from working capital.

(6) The provider must have a legal obligation to pay the interest.

(c) "Proper" requires that:

(1) Interest be incurred at a rate not in excess of what a prudent buyer would have

had to pay in the money market existing at the time the loan was made.

(2) Interest must be paid to a lender that is not a related party of the borrowing organization except as provided in paragraph (k).

(d) Interest expense shall be included in property costs if the interest is necessary and proper and if it is incurred as a result of financing the acquisition of fixed assets related to resident care.

(e) The date of such financing must be within 60 days of the date the asset is put in use, except for assets approved through the Certificate of Need process or approved by the Division under Subsection 4.11 of this rule. Allowable interest, on loans financed more than 60 days before or after the asset is put in use, will be included in Indirect Costs for the entire term of the loan.

(f) Borrowings to finance asset additions cannot exceed the sum of the basis of the asset(s), determined in accordance with Subsections 4.5 and 4.7, and other costs allowed pursuant to paragraph (g) related to the borrowing. The limit on borrowings related to fixed assets is determined as follows:

Basis of the assets recognized by the Division, plus a proportionate share of other costs allowed pursuant to paragraph (g), or

the principal amount of the loan, whichever is the lower:

Less: The provider's cash and cash equivalents in excess of 60 days needs, per subparagraph (b)(2) of this subsection.

Equals: The limits on borrowings related to fixed assets.

(g) Other costs related to the acquisition of the assets may be included in loans where the interest is recognized by the Division. These costs include bank finance charges, points and costs for legal and accounting fees, and discounts on debentures and letters of credit.

(h) Necessary and proper interest expense on debt incurred other than for the acquisition of assets shall be recognized as working capital interest expense and included in Indirect Costs.

(i) Application of Principal Payments.

(1) For loans entered into before a facility's 1998 fiscal year, principal payments shall be applied first to loan balances on allowable borrowings and second to non-allowable loan balances.

(2) For loans entered into during or after a facility's 1998 fiscal year, principal payments shall be applied to allowable and non-allowable loan balances on the ratio of each to the total amount of the loan.

(j) Refinancing of indebtedness.

(1) The provider must demonstrate to the Division that the costs of refinancing will be less than the allowable costs of the current financing.

(2) Costs of refinancing must include accounting fees, legal fees and debt acquisition costs related to the refinancing.

(3) Material interest expense related to the original loan's unpaid interest charges, to the extent that it is included in the refinanced loan's principal, shall not be allowed.

(4) A principal balance in excess of the sum of the principal balance of the previous financing plus accounting fees, legal fees and debt acquisition costs shall be considered a working capital loan, subject to the cash needs test in subsection 4.4(b)(2), unless the provider demonstrates to the Division that the excess was for the acquisition of assets as set forth in (a) through (g).

(k) Interest expense incurred as a result of transactions with a related party (or related parties) will be recognized if the expense would otherwise be allowable and if the following conditions are met:

(1) The interest expense relates to a first and/or second mortgage or to assets leased from a related party where the costs to the related party are recognized in lieu of rent.

(2) The interest rate is no higher than the rate charged by lending institutions at the inception of the loan.

(l) Interest is not allowable with respect to any capital expenditure in property, plant and equipment related to resident care which requires approval, if the necessary approval has not been granted.

(m) Interest on loans that do not include reasonable and ordinary principle repayments in the debt service payments shall not be allowable except to the extent that it would have been incurred pursuant to a standard amortization schedule for a term equivalent to the useful life of the asset.

4.5 Basis of Property, Plant and Equipment

(a) The basis of a donated asset is the fair market value.

(b) The basis of other assets that are owned by a provider and used in providing resident care shall generally be the lower of cost or fair market value. Specific exceptions are addressed elsewhere in this rule. Cost includes:

(1) purchase price,

(2) sales tax,

(3) costs to prepare the asset for its intended use, such as, but not limited to, costs of shipping, handling, installation, architectural fees, consulting and legal fees.

(c) The basis of assets constructed by the provider to provide resident care shall be determined from the construction costs which include:

(1) all direct costs, including, but not limited to, salaries and wages, the related payroll taxes and fringe benefits, purchase price of materials, sales tax, costs of shipping, handling and installation, costs for permits, architectural fees, consulting fees and legal fees.

(2) indirect costs related to the construction of the asset.

(3) interest costs related to capital indebtedness used to finance the construction of the asset and prepare it for its intended use.

(d) The basis of betterments or improvements, if they extend the useful life of an asset two or more years or significantly increase the productivity of an asset are costs as set forth in paragraphs (b) and (c) above.

(e) Any asset that has a basis of $2,000 or more and an estimated useful life of two or more years must be capitalized and depreciated in accordance with Subsection 4.6. Groups of assets with the majority of assets in the group valued at $300 or more and a useful life of two years or more must also be capitalized and depreciated in accordance with Subsection 4.6. Assets or groups of assets with a basis lower than $2,000 may be expensed or depreciated at the provider's election.

(f) The gain on a transfer of an asset to a related party shall be calculated as follows: the fair market value of the asset, less the net book value will be the gain irrespective of the of the amount paid to the facility for the asset. This gain will be offset against property and related costs.

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) Depreciation and amortization must be computed on the straight-line method.

(c) The depreciable basis of an asset shall be the basis established according to Subsections 4.5 and 4.7, net of any salvage value.

(d) The estimated useful life of an asset shall be determined by the Division as follows:

(1) The recommended useful life is the number of years listed in the most recent edition of Estimated Useful Lives of Depreciable Hospital Assets, published by the American Hospital Association.

(2) Leasehold improvements may be amortized over the term of an arms-length lease, including renewal period, if such a lease term is shorter than the estimated useful life of the asset.

4.7 Change in Ownership of Depreciable Assets - Sales of Facilities

(a) A change of ownership will be recognized when the following criteria have been met:

(1) The change of ownership did not occur between related parties, except for transactions that meet the criteria in subparagraph (2).

(2) The transaction takes place between family members and meets the following conditions:

(i) The Division shall be notified at least two years before the sale. The notice shall include a description of the terms and conditions of the sale and be accompanied by a current appraisal of the facility being sold.

(ii) The buyer shall demonstrate the capacity to manage and/or administer the facility; or if the buyer is to be an absentee owner, the buyer shall demonstrate that there will be sufficient capable staff to operate the facility according to standards prescribed by state and federal law.

(iii) The seller shall not maintain full time employment with the facility, except for a transition period which shall not be longer than one year during which the seller may provide reasonable consultation to assure a smooth transition.

(iv) A sale of the facility shall not have occurred between any members of the same family within the previous 12 years.

(v) For the purposes of this subsection, family members shall include spouses, parents, grandparents, children, grandchildren, brothers, sisters, spouses of parents, grandparents, children, grandchildren, brothers and sisters, aunts, uncles, nieces and nephews, or such other familial relationships as the Director may reasonably approve in the circumstances of the transaction.

(3) The change of ownership was made for reasonable consideration.

(4) The change of ownership was a bona fide transfer of all the powers and indicia of ownership.

(5) The change in ownership is in substance the sale of the assets or stock of the facility and not a method of financing.

(i) If the transferor and the transferee enter into a financing agreement, the agreement must be constructed to effect a complete change of ownership. The Division shall determine if the agreement does in substance effect a complete change of ownership and the Division shall monitor the compliance with the agreement.

(ii) Where, subsequent to a change of ownership, the transferor forgives or reduces the debt of the transferee, the amount of the forgiveness or reduction shall be retroactively applied to the acquisition or basis of the asset as determined by the Division.

(6) The buyer shall demonstrate to the satisfaction of the Division that all obligations to the State of Vermont arising out of the transaction have been satisfied.

(7) For rate setting purposes, the transfer of stock or shares shall not be recognized as a change in ownership in the following circumstances:

(i) the transferred stock or shares are those of a publicly traded corporation.

(ii) the transfer was made solely as a method of financing (not as a method of transferring management or control) and the number of shares transferred does not exceed 25 percent of the total number of shares in any one class of stock.

(b) Where the Division recognizes the change in ownership of an asset, the basis of the assets for the new owner shall be determined as follows:

(1) If the seller did not own the assets during the entire twelve year period immediately preceding the change in ownership or if the seller's facility did not receive Vermont Medicaid reimbursement during the entire twelve year period immediately preceding the change in ownership, the depreciable cost basis of the transferred asset for the new owner shall be the lowest of:

(i) the fair market value of the assets,

(ii) the acquisition cost of the asset to the buyer,

(iii) the original basis of the asset to the seller as recognized by the Division, less accumulated depreciation.

(2) If the seller owned the assets during the entire twelve year period immediately preceding the change in ownership and if the seller's facility received Vermont Medicaid reimbursement during the entire twelve year period immediately preceding the change in ownership, the depreciable cost basis of the transferred fixed equipment and building improvements for individual assets having an original useful life of at least 20 years in agreement with the useful life assigned in the American Hospital Association guidelines, the depreciable cost basis of land improvements, the depreciable cost basis of buildings and the cost basis of land for the new owner shall be the lowest of:

(i) the fair market value of the assets,

(ii) the acquisition cost of the asset to the buyer,

(iii) the amount determined by the revaluation of the asset. An asset is revalued by increasing the original basis of the asset to the seller, as recognized by the Division, by an annual percentage rate. The annual percentage rate will be limited to the lower of:

(A) One-half the percentage increase in the Consumer Price Index (CPI) for All Urban consumers (United States City Average).

(B) One-half the percentage change in an appropriate construction cost index as determined by the Division of Rate Setting, which change shall not be greater than one-half of the percentage increase in the Dodge Construction index (or a reasonable proxy therefor) for the same period.

(3) If the seller owned the assets during the entire twelve year period immediately preceding the change in ownership and if the seller's facility received Vermont Medicaid reimbursement during the entire twelve year period immediately preceding the change in ownership, the depreciable cost basis of individual assets categorized as building improvements and fixed equipment with an original useful life of less than 20 years, in agreement with the useful life assigned in the American Hospital Association guidelines, shall be the seller's net book value and shall be depreciated over a useful life of seven years.

(4) If the seller owned the assets during the entire twelve year period immediately preceding the change in ownership and if the seller's facility received Vermont Medicaid reimbursement during the entire twelve year period immediately preceding the change in ownership, the depreciable cost basis of moveable equipment and vehicles shall be the seller's net book value and shall be depreciated over a useful life of ten years.

4.8 [Repealed]

4.9 Leasing Arrangements for Property, Plant and Equipment

Leasing arrangements for property, plant and equipment must meet the following conditions:

(a) Rent expense on facilities and equipment leased from a related organization will be limited to the Medicaid allowable interest, depreciation, insurance and taxes incurred for the year under review, or the price of comparable services or facilities purchased elsewhere, whichever is lower.

(b) Rental or leasing charges, including sale and leaseback agreements for property, plant and equipment to be included in allowable costs cannot exceed the amount which the provider would have included in allowable costs had it purchased or retained legal title to the asset, such as interest on mortgage, taxes, insurance and depreciation.

4.10 Funding of Depreciation

(a) Funding of depreciation is not required, but it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciable assets, and coordinate their planning of capital expenditures with area-wide planning of community and state agencies. As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense.

(b) To the extent that the provider fails to retain sufficient working capital or sufficient resources to support operations, before making deposits in a funded depreciation account, the deposits will not be recognized as funded depreciation.

(c) To the extent that funded depreciation in the cost reporting period under consideration is used for purposes other than nursing facility asset acquisition, interest income on those sums will be offset against interest expense not only in the current period, but the Division may reopen settled cost reports for previous periods to revise funded depreciation and allowable interest expense. However, with the prior approval of the Division, under appropriate conditions, some or all of a provider's funded depreciation may be used as follows without triggering an interest income offset:

(1) to convert existing nursing home beds to residential care or assisted living, or

(2) when more economic, for new construction of residential care or assisted living units with a reduction in licensed nursing home beds.

(d) All relevant provisions of CMS-15 shall be followed, except as noted below:

(1) Replacement reserves. Some lending institutions require funds to be set aside periodically for replacement of fixed assets. The periodic amounts set aside for this purpose are not allowable costs in the period expended, but will be allowed when withdrawn and utilized either through depreciation or expense after considering the usage of these funds. Since the replacement reserves are essentially the same as funded depreciation the same regulations regarding interest will apply.

(2) If a facility is leased from an unrelated party and the ownership of the reserve rests with the lessor, then the replacement reserve payment becomes part of the lease payment and is considered an allowable cost in the year expended. If the lessee is allowed to use this replacement reserve for the replacement of the lessee's assets, lessee shall not be allowed to depreciate the assets purchased.

(e) The provider must maintain appropriate documentation to support the funded depreciation account and income earned thereon to be eligible for relief from the investment income offset.

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 subsection, 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 Subsection 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 subsection 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 subsection 8.7(b), but are subject to the other provisions of subsection 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.

4.12 [Repealed]

4.13 Advertising Expenses

The reasonable and necessary expense of newspaper or other public media advertisement for the purpose of securing necessary employees is an allowable cost. No other advertising expenses are allowed.

4.14 Barber and Beauty Service Costs

The direct costs of barber and beauty services are not allowable for purposes of Medicaid reimbursement. However, the fixed costs for space and equipment related to providing these services and overhead associated with billing for these services are allowable.

4.15 Bad Debt, Charity and Courtesy Allowances

Bad debts, charity and courtesy allowances are deductions from revenues and are not to be included in allowable costs.

4.16 Child Day Care

Reasonable and necessary costs incurred for the provision of day care services to children of employees performing resident related functions will be allowable. Costs will be adjusted by any revenues received for the provision of care provided to employees' children. The direct and indirect expenses related to providing these services to non-employee children are not an allowable expense. Costs must be accumulated in a separate cost center. Revenues earned from providing day care must be identified for employees and non-employees in a separate account.

4.17 Community Service Activities

As an incentive for nursing home providers to furnish needed services (i.e., meals-on-wheels, adult day and certain respite care, etc.) to local communities, with the prior permission of the Division, only direct identifiable incremental costs will be adjusted (i.e., food, direct labor and fringe benefits, transportation). Overhead costs will not be apportioned for adjustment unless there is a significant expansion to a program resulting from community service involvement. The provider must maintain auditable records for all incremental direct costs associated with providing a community service.

4.18 Dental Services

Costs incurred for services performed in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth will not be allowed for the purposes of calculating the per diem rate. Dental services for Medicaid eligible individuals are covered pursuant to the *Medicaid Covered Services Rules*. However, the fixed costs for space and equipment related to providing these services and overhead associated with billing for these services may be allowable.

4.19 Legal Costs

Necessary, ordinary, and reasonable legal fees incurred for resident-related activities will be allowable.

4.20 Litigation and Settlement Costs

(a) Civil and criminal litigation -

(1) General Rule. Attorney fees and other expenses incurred in conjunction with litigation will be recognized only to the extent that the costs are related to resident care, that the provider prevails, and that the costs are not covered by insurance.

(2) Settlements. In instances, where a matter is settled before judgment (whether or not a lawsuit has been commenced), one half the costs, including attorney fees, settlement award, and other expenses, relating to the matter will be recognized to the extent that the costs are related to resident care and are not covered by insurance.

(3) Costs related to criminal or professional practice matters are not allowable.

(b) Challenges to decisions of the Division - Attorney fees and other expenses incurred by a provider in challenging decisions of the Division will be allowed based on the extent to which the provider prevails as determined on the ratio of total dollars at issue in the case to the total dollars awarded to the provider.

(c) All costs recognized pursuant to this subsection shall be subject to the non-recurring costs provision in subsection 4.3(a)(2) or subsection 6.4.

4.21 Motor Vehicle Allowance

Cost of operation of a motor vehicle necessary to meet the facility needs is an allowable cost. Where the vehicle is used for personal and business purposes, the portion of vehicle costs associated with personal use will not be allowed. If the provider does not document personal use and business use under a pre-approved method, DRS reserves the right to disallow all vehicle costs in question. All costs in excess of the cost of a similar size mid-price vehicle are not allowable.

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.

4.23 Compensation of Owners, Operators, or their Relatives

(a) Facilities which have a full-time (40 hours per week minimum) administrator and/or assistant administrator, will not be allowed compensation for owners, operators, or their relatives who claim to provide some or all of the administrative functions required to operate the facility efficiently except in limited and special circumstances such as those listed in paragraph (b) of this subsection.

(b) The factors to be evaluated by the Division in determining the amount allowable for owner's compensation shall include, but not limited to the following:

(1) All applicable Medicare policies identified in CMS-15.

(2) The unduplicated functions actually performed, as described by the provider on the Medicaid cost report.

(3) The hours actually worked and the number of employees supervised, as reported on the cost report.

(c) For any facility fiscal year, the maximum allowable salary for an owner administrator shall be equal to 110 percent of the average of all reported administrator salaries for Vermont nursing facilities participating in the Medicaid program for that facility fiscal year.

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 subsection.

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.

4.26 Post-Retirement Benefits

The allowability of costs of certain benefits which may be available to retired personnel shall be governed by CMS-15, except that all such costs shall be included in fringe benefits and shall be allocated accordingly.

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.

4.28 Related Party

Expenses otherwise allowable shall not be included for purposes of determining a prospective rate where such expenses are paid to a related party unless the provider identifies any such related party and the expenses attributable to it and demonstrates that such expenses do not exceed the lower of the cost to the related party or the price of comparable services, facilities or supplies that could be purchased elsewhere. The Division may request either the provider or the related party, or both, to submit information, books and records relating to such expenses for the purpose of determining their allowability.

4.29 Revenues

Where a facility reports operating and non-operating revenues related to goods or services, the costs to which the revenues correspond are not allowable. If the specific costs cannot be identified, the revenues shall be deducted from the most appropriate costs. If the revenues are more than such costs, the deduction shall be equal to such costs.

4.30 Travel/Entertainment Costs

Only reasonable and necessary costs of meals, lodging, transportation and incidentals incurred for purposes related to resident care will be allowed. All costs determined to be for the pleasure and convenience of the provider or providers' representatives will not be allowed.

4.31 Transportation Costs

(a) Costs of transportation incurred, other than ambulance services for emergency transportation or transportation home from a nursing facility covered pursuant to the *Medicaid Covered Services Rules*, that are necessary and reasonable for the care of residents are allowable. Such costs shall include depreciation of utility vehicles, mileage reimbursement to employees for the use of their vehicles to provide transportation for residents, and any contractual arrangements for providing such transportation. Such costs shall not be separately billed for individual residents.

(b) Transportation costs related to residents receiving kidney dialysis shall be reported in the Ancillary cost category, pursuant to subsection 6.7(a)(5).

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 REIMBURSEMENT STANDARDS

5.1 Prospective Case-Mix Reimbursement System

(a) In general, these rules set out incentives to control costs and Medicaid outlays, while promoting access to services and quality of care.

(b) Case-mix reimbursement takes into account the fact that some residents are more costly to care for than others. Thus the system requires:

(1) the assessment of residents on a form prescribed by the Director of the Division of Licensing and Protection;

(2) a means to classify residents into groups which are similar in costs, known as RUG IV (48 group version) and

(3) a weighting system which quantifies the relative costliness of caring for different classes of residents to determine the average case-mix score.

(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 Subsection 9.2.

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 8 and 10;

(2) in response to a decision by the Secretary pursuant to Subsection 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 Subsection 15.8;

(3) for mechanical computation or typographical errors;

(4) for a terminating facility or a facility in receivership, pursuant to Subsections 5.10, 8.3, and 10.2;

(5) as a result of revised findings resulting from the reopening of a settled cost report pursuant to Subsection 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 subsection 14.1(e)(2) or

(9) when revisions of final rates are necessary to pass the upper limits test in 42 C.F.R. §447.272.

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 subsection, "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).

5.4 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.

5.5 Upper Payment Limits

(a) Aggregate payments to nursing facilities pursuant to these rules may not exceed the limits established for such payment in 42 C.F.R. §447.272.

(b) If the Division projects that Medicaid payments to nursing facilities in the aggregate will exceed the Medicare upper limit, the Division shall adopt a rule limiting some or all of the payments to providers to the level that would reduce the aggregate payments to the Medicare upper limit.

5.6 Base Year

(a) A Base Year shall be a calendar year, January through December.

(b) All costs shall be rebased on July 1, 2007. Subsequent rebasing for Nursing Care costs shall occur two years after the last rebase of such costs. All costs shall be rebased no less frequently than every four years.

(c) For the purposes of rebasing, the Director may require individual facilities to file special cost reports covering the calendar year when this is not the facility's fiscal year or the Division may use the facility's fiscal year cost report adjusted by the inflation factors in subsection 5.8 to the Base Year. The Director may require audited financial statements for the special cost reporting period. The costs of preparing the special cost report and audited financial statements are the responsibility of the provider, without special reimbursement; however, for reporting purposes, these costs are allowable.

(d) The determination of a Base Year shall be subject of a notice of practices and procedures pursuant to Subsection 1.8(d) of these rules.

5.7 Occupancy Level

(a) A facility should maintain an annual average level of occupancy at a minimum of 90 percent of the licensed bed capacity.

(b) For facilities with less than 90 percent occupancy, the number of total resident days at 90 percent of licensed capacity shall be used, pursuant to section 7, in determining the per diem rate for all categories except the Nursing Care and Ancillary categories.

(c) The 90 percent minimum occupancy provision in paragraph (b) shall be waived for facilities with 20 or fewer beds or terminating facilities pursuant to Subsection 5.10, and when appropriate, for facilities operating under a receivership pursuant to Subsection 8.3.

(d) Decreasing the Number of Licensed Beds – For any facility that operated at less than 90 percent occupancy 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.

5.8 Inflation Factors

The Director shall use the most recent publication of the Health Care Cost Service available June 1 in the calculation of inflation factors, whether for rebase inflation calculations or annual inflation calculations. Different inflation factors are used to adjust different rate components. Subcomponents of each inflation factor are weighted in proportion to the percentage of actual allowable costs incurred by Vermont facilities for specific subcomponents of the relevant cost component. For example, if a cost in the Nursing Care cost component is 83.4 percent attributable to salaries and wages and 16.6 percent attributable to employee benefits, the weights for the two subcomponents of the Nursing Care inflation factor shall be 0.834 and 0.166 respectively. The weights for each inflation factor shall be recalculated no less frequently than each time the relevant cost category is rebased.

(a) The Nursing Care rate component shall be adjusted by an inflation factor that uses two price indexes to account for estimated economic trends with respect to two subcomponents of nursing costs: wages and salaries, and benefits. The price indexes for each subcomponent are the wages and salaries portion of the Health-Care Cost Service NHMB, and the employee benefits portion of the NHMB, respectively. An additional adjustment of one percentage point shall be made for every 12 month period, prorated for fractions thereof, from the midpoint of the base year to the midpoint of the rate year.

(b) The Resident Care Rate Component shall be adjusted by an inflation factor that uses four price indexes to account for estimated economic trends with respect to the subcomponents of Resident Care costs: wages and salaries, employee benefits, utilities, and food and all other Resident care costs. The price indexes for each subcomponent are: the wages and salaries portion of the Health-Care Cost Service NHMB, the employee benefits portion of the NHMB, the utilities portion of the NHMB, and the food portion of the NHMB respectively.

(c) The Indirect rate component shall be adjusted by an inflation factor that uses three price indexes to account for estimated economic trends with respect to three subcomponents of Indirect costs: wages and salaries, employee benefits, and all other indirect costs. The price indexes for each subcomponent are: the wages and salaries portion of the Health-Care Cost Service NHMB, the employee benefits portion of the NHMB and the NECPI-U (all items), respectively.

(d) The Director of Nursing rate component shall be adjusted by an inflation factor that uses two price indexes to account for estimated economic trends with respect to two subcomponents of Director of Nursing costs: wages and salaries and employee benefits. The price indexes for each subcomponent are: the wages and salaries portion of the Health-Care Cost Service NHMB, and the employee benefits portion of the NHMB, respectively.

(e) Pursuant to Subsection 1.8(d), the Division shall issue a description of the practices and procedures used to calculate and apply the Inflation Factors.

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 90 percent occupancy 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 4 and 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 subsection 3.2 for its first full fiscal year of operation.

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 subsection 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 subsection 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 Subsection 5.7, the limitations on costs in Section 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 subsection shall remain in effect for a period not to exceed six months.

6 BASE YEAR COST CATEGORIES FOR NURSING FACILITIES

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:

6.2 Nursing Care Costs

(a) Allowable costs for the Nursing Care component of the rate shall include actual costs of licensed personnel providing direct resident care, which are required to meet federal and state laws as follows:

(1) registered nurses,
(2) licensed practical nurses,
(3) certified or licensed nurse aides, including wages related to initial and on-going nurse aide training as required by OBRA,
(4) contract nursing,
(5) the MDS coordinator,
(6) fringe benefits, including child day care.

(b) Costs of bedmakers, geriatric aides, transportation aides, paid feeding/dining assistants, ward clerks, medical records librarians and other unlicensed staff will not be considered nursing costs. The salary and related benefits of the position of Director of Nursing shall be excluded from the calculation of allowable nursing costs and shall be reimbursed separately.

6.3 Resident Care Costs

Allowable costs for the Resident Care component of the rate shall include reasonable costs associated with expenses related to direct care. The following are Resident Care costs:

(a) food, vitamins and food supplements,
(b) utilities, including heat, electricity, sewer and water, garbage and liquid propane gas,
(c) activities personnel, including recreational therapy and direct activity supplies,
(d) Medical Director, Pharmacy Consultant, Geriatric Consultant, and Psychological/psychiatric Consultant,
(e) counseling personnel, chaplains, art therapists and volunteer stipends,
(f) social service worker,
(g) employee physicals,
(h) wages for paid feeding/dining assistants only for those hours that they are actually engaged in assisting residents with eating,
(i) fringe benefits, including child day care,
(j) such other items as the Director may prescribe by a practice and procedure issued pursuant to subsection 1.8(d).

6.4 Indirect Costs

(a) Allowable costs for the indirect component of the rate shall include costs reported in the following functional cost centers on the facility's cost report, including those extracted from a facility's cost report or the cost report of an affiliated hospital or institution.

(1) fiscal services,
(2) administrative services and professional fees,
(3) plant operation and maintenance,
(4) grounds,
(5) security,
(6) laundry and linen,
(7) housekeeping,
(8) medical records,
(9) cafeteria,
(10) seminars, conferences and other in-service training (except tuition for college credit in a discipline related to the individual staff member's employment or costs of obtaining a GED which shall be treated as fringe benefits),
(11) dietary excluding food,
(12) motor vehicle,
(13) clerical, including ward clerks,
(14) transportation (excluding depreciation),
(15) insurances (director and officer liability, comprehensive liability, bond indemnity, malpractice, premise liability, motor vehicle, and any other costs of insurance incurred or required in the care of residents that has not been specifically addressed elsewhere),
(16) office supplies/telephone,
(17) conventions and meetings,
(18) EDP bookkeeping/payroll,
(19) fringe benefits including child day care.

(b) All expenses not specified for inclusion in another cost category pursuant to these rules shall be included in the Indirect Costs category, unless the Director at her/his discretion specifies otherwise in the instructions to the cost report, the chart of accounts, or by the issuance of a practice and procedure. For nursing facility rate setting, the costs of prescription drugs are not allowable.

6.5 Director of Nursing

Allowable costs associated with the position of Director of Nursing shall include reasonable salary for one position and associated fringe benefits, including child day care.

6.6 Property and Related

(a) The following are Property and Related costs:

(1) depreciation on buildings and fixed equipment, major movable equipment, minor equipment, computers, motor vehicle, land improvements, and

amortization of leasehold improvements and capital leases,
(2) interest on capital indebtedness,
(3) real estate leases and rents,
(4) real estate/property taxes,
(5) all equipment irrespective of whether it is capitalized, expensed, or rented,
(6) fire and casualty insurance,
(7) amortization of mortgage acquisition costs.

(b) For a change in services, facility, or a new health care project with projected property and related costs of $250,000 or more, providers shall give written notice to the Division no less than 60 days before the commencement of the project. Such notice shall include a detailed description of the project and detailed estimates of the costs.

6.7 Ancillaries

(a) The following are ancillary costs:

(1) All physical, speech, occupational, respiratory, and IV therapy services and therapy supplies (excluding oxygen) shall be considered ancillaries. Medicaid allowable costs shall be based on the cost-to-charge ratio for these services. These therapy services shall not be allowable for Medicaid reimbursement pursuant to this subsection unless:

(i) the services are provided pursuant to a physician's order,

(ii) the services are provided by a licensed therapist or other State certified or registered therapy assistant, or qualified IV professional, or other therapy aides,

(iii) the services are not reimbursable by the Medicare program, and

(iv) the provider records charges by payor class for all units of these services.

(2) Medical supplies, whether or not the provider customarily records charges.

(i) Medical supplies shall include, but are not limited to: oxygen, disposable catheters, catheters, colostomy bags, drainage equipment, trays and tubing.

(ii) Medical supplies shall not include rented or purchased equipment, with the exception of rented or purchased oxygen concentrators, which shall be included in medical supplies.

(3) Over-the-counter drugs. All drug costs may be disallowed for providers commingling the costs of prescription drugs (which are not allowable) and over-the-counter drugs.

(4) Incontinent Supplies and Personal Care Items: including adult diapers, chux and other disposable pads, personal care items, such as toothpaste, shampoo, body powder, combs, brushes, etc.

(5) Dialysis Transportation. The costs of transportation for Medicaid residents receiving kidney dialysis shall be included in the ancillary cost category. Allowable costs may include contract or other costs, but shall not include employee salaries or wages or cost associated with the use of provider-owned vehicles.

(6) Overhead costs related to ancillary services and supplies are included in ancillary costs.

(b) [Repealed]

7 CALCULATION OF COSTS, LIMITS AND RATE COMPONENTS FOR NURSING FACILITIES

Base year costs, rates, and category limits are calculated pursuant to this section. The Medicaid per diem payment rate for each facility is calculated pursuant to Section 9.

7.1 Calculation of Per Diem Costs

Per diem costs for each cost category, excluding the Nursing Care and Ancillary

cost categories, are calculated by dividing allowable costs for each case-mix category by the greater of actual bed days of service rendered, including revenue generating hold/reserve days, or the number of resident days computed using the minimum occupancy at 90 percent of the licensed bed capacity during the cost period under review calculated pursuant to subsection 5.7.

7.2 Nursing Care Component

(a) Case-Mix Weights.

There are 48 case-mix resident classes. Each case-mix class has a specific case-mix weight as follows:

Group Code	Case-Mix Weight	Description
ES3	3.00	Extensive Services
ES2	2.23	Extensive Services
ES1	2.22	Extensive Services
RAE	1.65	Rehabilitation
RAD	1.58	Rehabilitation
RAC	1.36	Rehabilitation
RAB	1.10	Rehabilitation
RAA	0.82	Rehabilitation
HE2	1.88	Special Care High
HE1	1.47	Special Care High
HD2	1.69	Special Care High
HD1	1.33	Special Care High
HC2	1.57	Special Care High
HC1	1.23	Special Care High
HB2	1.55	Special Care High
HB1	1.22	Special Care High
LE2	1.61	Special Care Low
LE1	1.26	Special Care Low
LD2	1.54	Special Care Low
LD1	1.21	Special Care Low
LC2	1.30	Special Care Low
LC1	1.02	Special Care Low
LB2	1.21	Special Care Low
LB1	0.95	Special Care Low
CE2	1.39	Clinically Complex
CE1	1.25	Clinically Complex
CD2	1.29	Clinically Complex
CD1	1.15	Clinically Complex
CC2	1.08	Clinically Complex
CC1	0.96	Clinically Complex
CB2	0.95	Clinically Complex
CB1	0.85	Clinically Complex
CA2	0.73	Clinically Complex
CA1	0.65	Clinically Complex
BB2	0.81	Behavioral Symptoms Plus Cognitive Performance
BB1	0.75	Behavioral Symptoms Plus Cognitive Performance
BA2	0.58	Behavioral Symptoms Plus Cognitive Performance
BA1	0.53	Behavioral Symptoms Plus Cognitive Performance
PE2	1.25	Reduced Physical Function
PE1	1.17	Reduced Physical Function
PD2	1.15	Reduced Physical Function
PD1	1.06	Reduced Physical Function
PC2	0.91	Reduced Physical Function
PC1	0.85	Reduced Physical Function
PB2	0.70	Reduced Physical Function
PB1	0.65	Reduced Physical Function
PA2	0.49	Reduced Physical Function
PA1	0.45	Reduced Physical Function

(b) Average case-mix score

The Department of Disabilities, Aging and Independent Living's Division of Licensing and Protection shall compute each facility's average case-mix score.

(1) The Division of Licensing and Protection shall periodically, but no less frequently than quarterly, certify to the Division of Rate Setting the average case-mix score for those residents of each facility whose room and board (excluding resident share) is paid for solely by the Medicaid program.

(2) For the Base Year, the Division of Licensing and Protection shall certify the average case-mix score for all residents.

(c) Nursing Care cost per case-mix point. Each facility's Nursing Care cost per case-mix point will be calculated as follows:

(1) Using each facility's Base Year cost report, the total allowable Nursing Care costs shall be determined in accordance with Subsection 6.2.

(2) Each facility's Standardized Resident Days shall be computed by multiplying total Base Year resident days by that facility's average case-mix score for all residents for the four quarters of the cost reporting period under review.

(3) The per diem nursing care cost per case-mix point shall be computed by dividing total Nursing Care costs by the Base Year Standardized Resident Days for that Base Year.

(d) Per diem limits on the Base Year allowable Nursing Care rate per case-mix point:

(1) The Division shall array all nursing care facilities' allowable Base Year per diem Nursing Care costs per case-mix point, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high. These costs shall be limited to the cost at the ninetieth percentile, calculated using the percentile spreadsheet function.

(2) Each facility's Base Year Nursing Care rate per case-mix point shall be the lesser of the limit in subparagraph (1) or the facility's allowable Nursing Care cost per case-mix point.

7.3 Resident Care Base Year Rate

Resident Care Base Year rates shall be computed as follows:

(a) Using each facility's Base Year cost report, the provider's Base Year total allowable Resident Care costs shall be determined in accordance with Subsection 6.3.

(b) The Base Year per diem allowable Resident Care costs for each facility shall be calculated by dividing the Base Year total allowable Resident Care costs by total Base Year resident days.

(c) The Division shall array all nursing facilities' Base Year per diem allowable Resident Care costs, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high and identify the median.

(d) The per diem limit shall be the median plus five percent.

(e) Each facility's Base Year Resident Care per diem rate shall be the lesser of the limit set in paragraph (d) or the facility's Base Year per diem allowable Resident Care costs.

7.4 Indirect Base Year Rate

Indirect Base Year rates shall be computed as follows:

(a) Using each facility's Base Year cost report, each provider's Base Year total allowable Indirect costs shall be determined in accordance with Subsection 6.4.

(b) The Base Year per diem allowable Indirect costs for each facility shall be calculated by dividing the Base Year total allowable Indirect costs by total Base Year resident days.

(c) The Division shall array all nursing facilities' Base Year per diem allowable Indirect costs, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high and identify the median.

(d) The per diem limit shall be set as follows:

(1) For special hospital-based nursing facilities, the limit shall be 137 percent of the median.

(2) For all other privately-owned nursing facilities, the limit shall be the median plus five percent.

(e) Each provider's Base Year Indirect per diem rate shall be the lesser of the limit in paragraph (d) or the facility's Base Year per diem allowable Indirect costs.

7.5 Director of Nursing Base Year Rate

The Director of Nursing Base Year per diem rates shall be computed as follows:

(a) Using each facility's Base Year cost report, total allowable Base Year Director of Nursing costs shall be determined in accordance with Subsection 6.5.

(b) Each facility's Base Year per diem allowable Director of Nursing costs shall be calculated by dividing the Base Year total allowable Director of Nursing costs by total Base Year resident days.

(c) The Director of Nursing per diem rate shall be the facility's Base Year per diem allowable Director of Nursing costs calculated pursuant to this subsection.

7.6 Ancillary Services Rate

(a) The Ancillary per diem rate shall be computed as follows:

(1) Medicaid Ancillary costs shall be determined in accordance with subsection 6.7.

(2) Using each facility's most recently settled cost report, the per diem Ancillary rate shall be the sum of the following per diem costs calculated as follows:

(i) Costs for therapy services per diem, including IV therapy, shall be calculated by dividing allowable Medicaid costs by the number of related Medicaid resident days less Medicaid hold days.

(ii) Dialysis transportation costs per diem shall be calculated by dividing the allowable costs for Vermont Medicaid residents by the number of Vermont Medicaid resident days less Vermont Medicaid hold days.

(iii) Costs for medical supplies, over-the-counter drugs, and incontinent supplies and personal care items per diem shall be calculated by dividing allowable costs, by total resident days less hold days.

(b) Any change to the Ancillary per diem rate shall be implemented at the time of the first quarterly case-mix rate recalculation after the cost report is settled.

7.7 Property and Related Per Diem

The Property and Related per diem rate shall be computed as follows:

(a) Using each facility's most recently settled annual cost report, total allowable Property and Related costs shall be determined in accordance with Subsection 6.6.

(b) Using each facility's most recently settled cost report, the per diem property and related costs shall be calculated by dividing allowable property and related costs by total resident days. Any change to the property and related per diem rate shall be implemented at the time of the first quarterly case-mix rate recalculation after the cost report is settled.

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, the limits set pursuant to subsections 7.2(d)(2), 7.3(d), and 7.4(d) 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.

8 ADJUSTMENTS TO RATES

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.

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.

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.

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.

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 subsection for a period of up to two years.

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.

8.7 Procedures and Requirements for Rate Adjustments

(a) Application for a rate adjustment pursuant to this section should be made as follows. Approval of any application for a rate adjustment under this section is at the sole discretion of the Director.

(b) Except for applications made pursuant to subsection 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.

(c) 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 proofs 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. Principles and decisions of general applicability shall be issued as a Division practice or procedure, pursuant to Section 1.8(d).

(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, <u>or, at the discretion of the Division, the first day of the quarter immediately preceding the final order</u> 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 subsection 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 subsection 5.9. Appropriate cases may include, but are not limited to, changes in the number of beds, an addition to the facility, or the replacement of existing property.

(k) In calculating an adjustment under this section and subsection 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 subsection 4.11 based on a "look-back" which will be computed based on a provider's actual allowable costs.

(m) In this subsection "additional costs" means the incremental costs of providing resident care directly and proximately caused by one of the events listed in this section or subsection 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.

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.

9 PRIVATE NURSING FACILITY AND STATE NURSING FACILITY RATES

The Medicaid per diem payment rates for nursing home services are calculated according to this section as follows:

9.1 Nursing Facility Rate Components

The per diem rate of reimbursement consists of the following rate components:

(a) Nursing Care
(b) Resident Care
(c) Indirect
(d) Director of Nursing
(e) Property and Related
(f) Ancillaries
(g) Adjustments (if any)

9.2 Calculation of the Total Rate

The total per diem rate in effect for any nursing facility shall be the sum of the rates calculated for the components listed in Subsection 9.1, adjusted in accordance with the Inflation Factors, as described in Subsection 5.8.

9.3 Updating Rates for a Change in the Average Case-Mix Score

(a) The Nursing Care rate component shall be updated quarterly, on the first day of January, April, July and October, for changes in the average case-mix score of the facility's Medicaid residents.

(b) The Nursing Care rate component and any part of a Section 8 adjustment that reimburses nursing costs are updated for a change in the average case-mix score for the facility's Medicaid residents. The update is calculated as follows:

(1) The Nursing Care rate component (or rate adjustment) in the current rate of reimbursement for a facility is divided by the average case-mix score used to determine the current Nursing Care rate component. This quotient is the current Nursing Care rate per case-mix point.

(2) The current Nursing Care rate component (or rate adjustment) per case-mix point is multiplied by the new average case-mix score. This product is the new Nursing Care rate component (or rate adjustment).

<u>(c) the Division may use an average of the case-mix scores from the two most recent available quarters having complete case-mix score data if nursing facilities are temporarily exempt from any part of the standard minimum data set (MDS) reporting requirements by CMS as a result of the National Health Emergency declared in response to the COVID-19 pandemic and do not submit updated or complete MDS data to the Department of Disabilities, Aging and Independent Living.</u>

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 3 and 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.

(d) At no time shall the final rates paid to State nursing facilities exceed the upper limits established in 42 C.F.R. §447.272.

9.5 Quality Incentives

Certain awards shall be made annually to facilities that provide a superior quality of care in an efficient and effective manner.

(a) These payments will be based on:

(1) objective standards of quality, which shall include resident satisfaction surveys, to be determined by the Department of Disabilities, Aging and Independent Living, and

(2) objective standards of cost efficiency determined by the Division.

(b) Supplemental payments will not be available under this subsection for any facility that does not participate in the statewide resident satisfaction survey program.

(c) Supplemental payments shall be expended by the provider to enhance the quality of care provided to Medicaid eligible residents. In determining the nature of these expenditures, the provider shall consult with the facility's Resident Council.

(d) The amount and method of distribution of the quality incentive payments shall be as follows:

(1) The quality incentive payments shall be made from a pool. The annual size of the pool shall be based on the amount of $25,000 times the number of facilities meeting the award criteria, up to a maximum of five.

(2) The pool shall be distributed among the qualifying facilities, awarding each qualifying facility a share of the pool based on the ratio of its Medicaid days to the total Medicaid days for all the qualifying facilities.

(e) Award Criteria

The following criteria will be applied to facility data up to March 31 each year to determine eligibility for the award to be presented in May. In order to be eligible for the award, a facility must participate in the Vermont Medicaid program and meet all of the following criteria. All eligible facilities will be ranked according to their quality of care by the Department of Disabilities, Aging and Independent Living based on these basic quality criteria. The five facilities with the highest quality of care will receive an award. If, based on the basic criteria, there are ties which would cause more than five facilities to be equally qualified, the tied facilities will be ranked according to the efficiency criteria set out below in paragraph (6), to determine those facilities that will receive an award.

(1) The most recent health survey report resulted in a score of five or less, no deficiency with a scope and severity greater than "D" level, with no more than two "D" level deficiencies in the general categories of Quality of Care, Quality of Life, or Resident Rights.

(2) No substantiated complaints since the most recent survey and prior full health survey related to quality of care, quality of life, or residents' rights.

(3) Participation in Advancing Excellence in America's Nursing Homes campaign.

(4) Resident satisfaction survey results above the statewide average.

(5) Fire Safety deficiency score of 5 or less with scope and severity less than "E" in the most recent full survey.

(6) The efficiency rankings shall be based upon the allowable costs per day from each facility's most recently settled Medicaid cost report. Cost per day will be calculated using actual resident days for the same fiscal period.

10 EXTRAORDINARY FINANCIAL RELIEF

10.1 Objective

In order to protect Medicaid recipients from the closing of a nursing facility in which they reside and to provide financial relief to nursing facilities in response to the State of Emergency declared by the Governor of the State of Vermont on March 13, 2020 related to the COVID-19 outbreak, this section establishes a process by which nursing ~~homes~~ facilities that are in immediate danger of failure or that are experiencing unexpected financial burdens related to COVID-19 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.

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~~Commissioner of the Department of Vermont Health Access 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~~Commissioner. The interim financial relief shall be taken into account in the Division's Recommendation to the ~~Secretary~~Commissioner and in the ~~Secretary's~~ Commissioner's Final Decision.

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 or that the relief sought is a result of unexpected costs associated with the COVID-19 State of Emergency.

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

(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.

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~~ Commissioner 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.

11 PAYMENT FOR OUT-OF-STATE PROVIDERS

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.

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.

(b) 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 Subsection 11.1.

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.

12 RATES FOR ICF/MRS

12.1 Reasonable Cost Reimbursement

Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are paid according to Medicaid principles of reimbursement, pursuant to the *Regulations Governing the Operation of Intermediate Care Facilities for the Mentally Retarded* adopted by the Agency.

12.2 Application of these Rules to ICF/MRS

The Division's Accounting Requirements (Section 2) and Financial Reporting (Section 3) shall apply to this program.

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 14 and subsection 9.5 shall not be included in the calculation of swing-bed rates.

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 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 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 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 other similarly situated individuals as the Commissioner of Mental Health shall approve. The rate shall be prospective and shall be set before admission of the individual to the facility.

(1) The special rate payable for each individual shall consist of the current per diem rate for the receiving facility as calculated pursuant to Sections 5 to 9 of these rules and a monthly supplemental incentive payment. Three levels of supplemental payments are available for the care of residents meeting the eligibility criteria in this subsection based on the severity of the resident's condition and the resources needed to provide care.

(2) The supplemental payment will continue to be paid as long as the criteria in paragraph (c) are satisfied.

(b) To be eligible for a special rate, the receiving facility must have in place a plan of care developed in conjunction with and approved by the Commissioner of Mental Health and the Division of Licensing and Protection.

(c) Criteria for continuation of supplemental payments:

(i) The transferred person continues to reside at the receiving facility.

(ii) The facility documents to the satisfaction of the Division of Licensing and Protection that the transferred person continues to present significant behavior management problems by exhibiting behaviors that are significantly more challenging than those of the general nursing facility population.

(d) Any advance payments for days during which the transferred person is not resident or ceases to be eligible for the special transitional rate will be treated as overpayments and subject to refund by deductions from the provider's Medicaid payments.

14.3 Special Rates for Medicaid Eligible Furloughees of the Department of Corrections

A special rate equal to 150 percent of a nursing facility's ordinary Medicaid rate shall be paid for care provided to Medicaid eligible furloughees of the Department of Corrections.

15 ADMINISTRATIVE REVIEW AND APPEALS

15.1 Draft Findings and Decisions

(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.

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 Subsection 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 Subsection 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 Subsection 15.2(a), the Division's draft findings and/or decision are final and no longer subject to administrative review or judicial appeal.

15.3 Request for Reconsideration

(a) A provider that is aggrieved by an official action issued pursuant to Subsection 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 subsection 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.

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 Subsections 15.5, 15.6 and 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.

(i) 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.

(ii) 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.

(2) 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.

(i) 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.

(ii) 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.

(iii) 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.

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

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) A party aggrieved by a Final Determination of the Secretary may obtain judicial review pursuant to 33 V.S.A. §909(a)(1) and (2) and Subsections 15.6 and 15.7 of this Rule.

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.

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.

15.8 Settlement Agreements

The Director may agree to settle reviews and appeals taken pursuant to Subsections 15.3 and 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.

16 DEFINITIONS AND TERMS

For the purposes of these rules the following definitions and terms are used:

Accrual Basis of Accounting: 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.

Agency: the Agency of Human Services.

AICPA: American Institute of Certified Public Accountants.

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

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

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

Centers for Medicare and Medicaid Services(CMS) (formerly called the Health Care Financing Administration (HCFA)): Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.

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, 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.

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

Notwithstanding any other provisions of these rules, the amendments to these rules effective March 6, 2015 shall be applied to payments for services rendered on or after March 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 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. 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.