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Nursing Facility Provider Manual

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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Section 1 Introduction

This manual supplements existing federal and state law, primarily including the Division of Rate Setting's *Methods, Standards and Principles for Establishing Medicaid Payment Rates for Long-Term Care Facilities* (V.D.R.S.R.). This manual applies to nursing facilities licensed by the Department of Disabilities, Aging, and Independent Living that provide care to Medicaid residents and that receive per diem Medicaid rates from the Division under V.D.R.S.R. § 1.2.

This manual describes the main aspects of the rate-setting process, including how and when providers must file cost reports (Section 3), how the Division determines which costs are allowable (Section 4), any adjustments and caps that may apply to a facility (Section 5), how the Division allocates costs within categories (Section 6), how the Division calculates rate components (Section 7), how the Division calculates final per diem rates for private facilities (Section 8), and how providers can apply for special rates for specific residents (Section 9).

Section 2 General Provisions

2.1 Representation in DRS Matters

Nursing facility providers can be complex organizations with multiple administrative staff, attorneys, accountants, or other personnel who may need or desire to receive notices of decisions that affect the provider. Accordingly, the V.D.R.S.R. Section 1.11 requires providers to notify the Division of all personnel who shall receive notices of Division decisions.

Providers may identify both general and special representatives to receive notices. A general representative is an individual who shall receive notice of all Division decisions with respect to that provider. A special representative is an individual who shall receive notice of all Division decisions with respect to one matter, such as an appeal of an adjustment or a request for a rate adjustment.

Providers may select more than one representative of either type. Providers may select only nursing home administrators, licensed attorneys, or certified public accountants as their representatives, and may not be represented by laypeople or clinicians.

Providers must use forms the Division has created to identify general and special representatives. To download copies of the forms, visit the Division's website. The forms may include additional requirements, such as listing a representative's address and title and requiring the representative to affirm that they have the authority to receive notifications from the Division.

When a provider names a representative, the representative must select if they wish to be served documents by mail, fax, or email. If a provider chooses to be served documents by fax or email, they consent to the risks of electronic communications, including the risk that an email may be unsent because of file size limitations.

If a provider has multiple representatives that share a physical address and request notice by mail, the Division shall not send duplicate copies of documents to that physical address.

2.2 Procurement Standards

Providers must establish and maintain a code of standards to assess the performance of employees who procure goods and services. The standards must provide, to the extent practicable, that the provider values open and free competition among multiple vendors. Providers should participate in group purchasing plans where feasible.

If a provider pays more than what the Division determines to be a competitive bid for a good or service, any amount over a lower bid that cannot be demonstrated to be a reasonable and necessary expenditure that satisfies the prudent buyer principle will not be an allowable cost under the Division's rules or this manual.

2.3 Cost Allocation Plans and Changes in Accounting Principles

2.3.1 In General

1. Any cost allocated to the nursing facility must be a reasonable cost.
2. The preferred statistical methods for allocating specific costs are as follows:
    a. Nursing supplies and salaries: direct costs
    b. Plant operations: square footage
    c. Utilities: square footage
    d. Laundry: pounds of laundry

e. Dietary: number of resident days
f. Administrative and general costs: accumulated costs
g. Property and related costs: square footage
h. Fringe benefits: direct allocation/gross salaries

2.3.2 Cost Allocation From Related Entities

A provider's corporate parent may allocate costs from related entities to the provider. If this occurs, when a provider submits their cost report under Section 3 of this manual, the provider must include a summary of the allocated costs and a reconciliation of the allocated costs with the audited financial statements required by Section 3. If the related entity is the provider's home office or management company, the provider's cost report must include a Home Office Cost Statement.

2.3.3 Recognizing Changes in Accounting Principles

The Division reserves the right not to recognize a change in accounting principles, methods, or bases of cost allocation if the Division finds that the change was intended to, or likely will, increase the provider's Medicaid payments.

2.3.4 Medicare Intermediary Requirements

Providers must notify the Division if the Medicare intermediary requires them to change how they allocate costs or keep records.

2.3.5 Dietary Costs Calculation

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

2.3.6 Utility Costs Calculation

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.

2.3.7 Allocated Cost Categories

1. All administrative and general costs that are allocated to a facility, including home office and management company costs, shall be included in the Indirect cost category.
2. 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, shall be considered as costs for that particular good or service and not classified as Property and Related costs of the nursing facility.

Section 3 Cost Reports

The Division's rules, V.D.R.S.R. § 3, require providers to file annual statistical and financial information in the form of a uniform report called a cost report. The cost report is the basis for all of the work done by the Division in setting a facility's rate. Providers should carefully ensure that they only report actual and allowable costs under this manual and the Division's rules. If the Division fails to correct an error on a provider's cost report that results in an increased rate, the provider may be liable for Medicaid waste, abuse, or fraud, or for filing a false claim.

The cost report template is available on the Division's website. Providers must file cost reports using this template. If a provider fails to file a cost report using this template, the Division shall reject the cost report. Cost reports must be signed by the facility's owner or by the owner's authorized representative.

In addition to the template cost report, providers must submit additional supporting documentation to justify the reported costs. If a provider fails to file this supporting documentation, the Division shall reject the cost report. Providers must submit:

- Audited financial statements, except that the Director may waive this requirement in writing.
- The provider's most recently filed Medicare Cost Report, including the required supplemental data on CMS Form 339.
    - If a provider does not participate in Medicare, this requirement does not apply.
    - If a provider is a hospital-based nursing home, the provider shall submit the Medicare Cost Report for the same fiscal year as the cost report required by this manual and the Division's rules.
- An independent auditor's adjusting entries and reconciliation of the audited financial statements to the cost report, except that if the Director waived the requirement to submit an audited financial statement, this requirement does not apply.

The Division may also request other data, statistics, or information as necessary to carry out its functions. If the Division requests other information while reviewing a provider's cost report, but the provider fails to submit the requested information, the requested information shall not be admissible at any other stage of the rate setting process, including any subsequent appeal of a final decision of the Division under Section 15 of the Division's rules.

3.1 Deadlines for Filing a Cost Report

All providers must file a cost report at least annually for the 12-month period that covers the provider's fiscal year. The Division may also request that a provider file a special cost report or a budget cost report covering a shorter or greater period of time. Providers must file an acceptable annual cost report according to the deadlines prescribed in Section 3.3(a) of the Division's rules.

3.2 Extensions for Filing a Cost Report

The Division may grant an extension to a provider who is unable to file an acceptable annual cost report according to the Section 3.3(a) deadline. To receive an extension, providers must file a request in writing on a form prescribed by the Division. Forms are available on the Division's website. The Division must receive the request before the deadline specified in Section 3.3(a). The request must clearly state the reason that the provider is requesting an extension and the date on which the Division will receive the cost report. If a request for an extension fails to meet these criteria, the Division shall reject the request for an extension.

The Division shall grant an extension only for good cause. Under this manual, "good cause" means a substantial reason that affords a legal excuse for a delay, an intervening action beyond the provider's control, or both. For example, the Division may find good cause exists for delay if a natural disaster prevents the cost report preparer from reporting to work in person or electronically, or a ransomware attack prevents the provider from accessing its records. The Division shall not find that good cause exists for extending a cost report deadline if the reason for the delay is ignorance of the rule, the inconvenience of preparing a cost report, or because the person who typically prepares the cost report is busy with other work.

3.3 Reopening and Correcting a Cost Report

The Division shall review cost reports under V.D.R.S.R. Section 3.4, and cost reports are settled under V.D.R.S.R. Section 3.5(a). After a cost report is settled, the Division may reopen and correct a cost report for certain narrow reasons.

3.3.1 Reopening

Upon request. The Division may reopen a cost report if the provider requests that the Division reopen the report and submits new and material evidence concerning an element of the cost report, unless the Division requested that evidence under Section 3 of this manual during its review of the cost report and the provider failed to submit it.

The Division shall only reopen a cost report at a provider's request if doing so would have a material effect on the provider's Medicaid rate payments. Reopening would have a material effect if the provider's rate payments would be adjusted by one percent or more.

Providers must file a request to reopen a cost report within 3 years of the date of the Division's final determination with respect to a cost report.

Upon receiving an order. The Division shall reopen a cost report if a court of competent jurisdiction or the Secretary of the Agency of Human Services orders that a Division decision is inconsistent with applicable law or rules. The Division shall reopen the cost report whether or not doing so would have a material effect under this section.

The Division shall reopen a cost report in response to an order within 3 years of the date of the order, or within a time period as specified by the order.

For cause. The Division may reopen a cost report for cause, as established elsewhere in this manual.

3.3.2 Correction

After the Division has reopened a cost report, the cost report may be corrected. A correction is a revision to a finding with respect to any aspect of an otherwise final cost report. The Division may request that a provider submit a corrected cost report, or the Division may correct a cost report itself in response to the information the provider submitted upon requesting to reopen the cost report. If the cost report has been reopened in response to an order from a court or the Secretary, the Division shall correct the cost report itself.

The Division may require or allow a cost report to be corrected to address material errors in the cost report or to comply with applicable law or rules.

Section 4 Allowable Costs

After receiving a cost report, the Division shall determine the allowability and reasonableness of the costs a provider reports as described in V.D.R.S.R. Section 4.1. In general, if the Division's rules, this manual, or CMS's Medicare Provider Reimbursement Manual (CMS-15) do not address whether a cost is allowable, the Division shall review the cost in accordance with Generally Acceptable Accounting Practices (GAAP).

This manual addresses specific categories of costs and addresses whether they are allowable or unallowable.

4.1 Non-Recurring Costs

Certain costs are non-recurring costs that shall be capitalized, amortized, and carried as an ongoing adjustment as described in V.D.R.S.R. Section 4.3.

In general. The Division may designate any reasonable, resident-related cost that exceeds $10,000 and that is not expected to recur at least annually as a non-recurring cost. If the cost would otherwise be assigned to a cost category that is subject to a limit or cap, the cost will continue to be subject to that limit or cap.

Litigation expenses. If the Division recognizes a litigation expense under Section 4.14 of this manual of $10,000 or more, the Division shall designate the expense a non-recurring cost.

Overseas recruitment. If a provider incurs more than $2,000 in lump sum costs for recruitment costs, including legal fees, associated with hiring nurses from countries outside the United States, the Division shall designate the expense a non-recurring cost under certain conditions. The Division shall only designate the expense as non-recurring if providers pay recruited nurses at least the prevailing salary or wage, including benefits, that employed nurses of similar qualifications and experience in the geographic area in which the facility is located would be paid.

Nurse aide training expenses. If Vermont Medicaid is required to reimburse for nurse aide training expenses under 42 C.F.R. § 483.152(c)(2), the Division shall designate the expense a non-recurring cost.

4.2 Interest Expense

V.D.R.S.R. Section 4.4(a) requires the Division to allow interest expenses that are necessary and proper.

4.2.1 Necessary Interest

Interest shall only be treated as "necessary" under the Division's rules when interest is incurred on a loan to satisfy a provider's financial need and the provider had a legal obligation to pay the interest. The Division shall find that a provider did not have a financial need when the provider had 60 days or more cash, or cash equivalents, on hand to pay for expenses at the time the provider took out the loan.

Cash equivalents include:

- monetary investments, including unrestricted grants and gifts,
- non-monetary investments unrelated to resident care that can be readily converted into cash, net of any associated liabilities or fees,

- receivables from members or owners of the corporate entity that controls the nursing home, officers, managers, employees, or related parties of the person or entity that controls the nursing home, excluding education loans to employees, and
- receivables that result from transactions not related to resident care.

Cash equivalents exclude:

- funded depreciation that has been recognized by the Division under its rules or this manual, and
- restricted grants and gifts.

4.2.2 Proper Interest

Interest expense shall only be treated as "proper" under the Division's rules when providers incur the interest at a rate not in excess what a prudent buyer would have had to pay in the money market existing at the time the loan was made.

Interest paid as part of a transaction with a related party or parties is not proper interest, unless:

- The interest expense relates to a first or second mortgage, or to assets leased from a related party where the costs to the related party are recognized in lieu of rent, or
- The interest rate is no higher than the rate charged by lending institutions at the inception of the loan.

Interest paid with respect to a capital expenditure in property, plant, or equipment that is related to resident care that requires approval from any governmental body, and for which the necessary approval was not granted, is not proper interest.

Interest on loans that do not include reasonable and ordinary principal repayments in the debt service payments is not proper interest, 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.

4.2.3 Offset

Interest expenses shall be reduced by realized investment income, except where that income is from funded depreciation that has been recognized by the Division under its rules or this manual, or where that income is from any grants or gifts. If the provider incurs interest expenses from working capital, the Division shall only offset these expenses using interest income derived from working capital.

4.2.4 Cost Category

Interest may be included in a provider's property costs if the interest is necessary and proper under the Division's rule and this manual and the provider incurs the interest as a result of financing an acquisition of fixed assets related to resident care. The provider must put the asset in use within 60 days of financing the acquisition unless the provider receives a Certificate of Need for the acquisition from the Green Mountain Care Board or the Division approves the acquisition under Section 4.11 of the Division's rules. If the provider does not put an asset in use within 60 days of financing the asset's acquisition, the interest cost shall be included in the provider's indirect costs for the entire term of the loan.

Interest expense on any debt incurred for a purpose other than acquiring an asset shall be recognized as working capital interest expense and included in a provider's indirect costs.

4.2.5 Limit on Borrowing

Borrowing to finance an additional asset or assets cannot a exceed certain amount, calculated as follows. The Division must determine the basis of the asset or assets and the principal amount of the loan to finance the asset or assets. The Division shall then determine the amount of cash or cash equivalents the provider has in excess of the amount the provider needs to pay expenses for the next 60 days. The Division shall subtract the amount of excess cash from the lower of the basis of the asset or the principal amount of the loan to finance the asset. This calculation shall serve as the limit on borrowings related to the asset.

When determining the basis of the asset under this section of the manual only, the Division may recognize other costs related to acquiring the asset, including bank finance charges, points and costs for legal and accounting fees, and discounts on debentures and letters of credit, and may add a proportional amount of those costs to the basis of the asset. When determining the basis of an asset in general, the Division shall follow Section 4.3 of this manual.

If borrowing to finance an additional asset exceeds the amount calculated under this section, the excessive amount is not allowable.

4.2.6 Application of Principal Payments

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.

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.

4.2.7 Refinancing

When refinancing debts, a provider must demonstrate that the costs of refinancing – including account fees, legal fees, and new debt acquisition costs – must be less than the allowable costs of the provider's current financing.

If the principal balance of a refinanced debt exceeds the principal balance of the previous debt plus accounting fees, legal fees, and debt acquisition costs, the Division shall consider the refinanced debt a working capital loan and must determine whether the loan is necessary under Section 4.2.1 of this manual. The provider may demonstrate the excess debt was incurred to acquire an asset under Sections 4.2.4 and 4.2.5 of this manual.

To the extent that a refinanced loan's principal includes material interest expense related to the original loan's unpaid interest charges, the refinanced loan's principal shall not be allowed.

4.3 Determining the Basis of Property, Plant, and Equipment

The basis of a donated asset is the fair market value of the asset. For all other assets that a provider owns and uses in providing resident care, the basis of the asset is the lower of either the cost of the asset or the fair market value of the asset, unless another provision of this manual or the Division's rules specifies a different method for determining an asset's basis.

An asset's cost, under this section, includes the asset's purchase price, any applicable sales tax, and any costs to prepare the asset for its intended use, including but not limited to shipping, handling, installation, consulting, legal fees, and architectural fees.

4.3.1 Basis of New Construction or Betterments and Improvements

Providers may construct new assets to provide resident care. The basis of a newly constructed asset's costs shall be determined from the costs of construction, which include:

- All direct costs, including but not limited to salaries and wages, related payroll taxes and fringe benefits, purchase price of materials, applicable sales taxes, shipping, handling, installation, permits, architectural fees, consulting fees, and legal fees,
- Indirect costs related to the construction of the asset,
- Interest costs related to capital indebtedness used to finance the construction of the asset and prepare it for its future use.

Providers may improve or better an asset. If an improvement or betterment extends the useful life of an asset two or more years, or significantly increases the productivity of an asset, the basis of the betterment or improvement shall be the costs of the improvement or betterment as if it was a new construction.

4.3.2 Assets with Significant Basis and Useful Life

Providers must capitalize and depreciate any asset with a basis of $2,000 or more and a useful life of two or more years in accordance with Section 4.4 of this manual. Providers must also capitalize and depreciate any groups of assets if the majority of the assets in the group have a basis of $300 or more and a useful life of two or more years in accordance with Section 4.4 of this manual. Providers may choose to capitalize and depreciate any other assets if doing so would be reasonable.

4.4 Requirement to Capitalize and Depreciate or Amortize Assets

Providers must compute depreciation and amortization on the straight-line method. The basis of each depreciated or amortized asset shall be the basis established under Section 4.3 and 4.5 of the manual, net of any salvage value of the asset.

In general, the Division estimates the useful life of an asset by referring to the most recent version of the Estimated Useful Lives of Depreciable Hospital Assets published by the American Hospital Association. If a provider has negotiated an arms-length lease of an asset, leasehold improvements may be amortized over the term of the lease if the term of the lease is shorter than the estimated useful life of the asset. The term of the lease includes any renewal period specifically stated in the lease.

4.5 Change in Basis of Depreciable Asset After Change of Ownership

After a qualifying change in ownership, the Division may recognize a new basis for an asset.

4.5.1 Qualifying Changes in Ownership

To benefit from this section, the change in ownership must meet each of the criteria (a) through (e):

a. The change of ownership was made for reasonable consideration,

b. The change of ownership was a bona fide transfer of all the powers and indicia of ownership,

c. All obligations to the State of Vermont that arise out of the transaction have been satisfied,

d. The change in ownership is in substance the sale of the assets or stock of the facility and not a method of financing, except that:

   (1) The transferor and transferee may enter into a financing agreement, but it must be constructed to effect a complete change of ownership. The Division shall monitor each

party's compliance with the agreement and may refuse to recognize a change of ownership,

(2) If the transferor forgives or reduces the debt of the transferee after the transaction is complete, the amount of the forgiveness or reduction shall be retroactively applied to the acquisition or basis of the asset, and

(3) A change in ownership that is effected by transferring stock or shares of a publicly traded corporation shall not be recognized as a change in ownership under this section, and

e. The change in ownership did not occur between related parties or related individuals, except that the Division may approve a transaction between family members under the following conditions:

(1) The family members notify the Division at least two years before the sale with a description of the terms and conditions of the sale and a current appraisal of the facility being sold,

(2) The buyer demonstrates that they or their staff shall capably operate the facility according to state and federal standards,

(3) The seller shall not remain employed with the facility full-time, except for a transition period which shall not be longer than one year, and

(4) The seller may not have purchased the facility from any members of their family within the previous 12 years.

For the purposes of this section only, "family members" include spouses, parents, grandparents, children, grandchildren, brothers, sisters, aunts, uncles, nieces, and nephews, including by marriage, or such other familial relationships as the Director may reasonably determine.

4.5.2 Change in Basis for Qualifying Transfers

When the Division recognizes a qualifying transfer under Section 4.5.1 of this manual, the basis of the assets for the new owner shall be determined as follows.

a. 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:

(1) the fair market value of the assets,

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

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

b. 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:

(1) the fair market value of the assets,

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

(3) 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.

c. 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.

d. 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.

4.6 Leasing Arrangement for Property, Plant, and Equipment

In general, providers may not use rental or leasing arrangements to inflate their allowable costs above what their costs would have been had they purchased the same services at market price.

If a provider leases facilities or equipment from a related organization, the provider's rent expense shall be limited to Medicaid allowable interest, depreciation, insurance, and taxes incurred for the year under review, or the price of comparable services or facilities purchased or leased elsewhere, whichever is lower.

Rent or lease charges, including sale and leaseback agreements for property, plant, and equipment that would otherwise be allowable, 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.

4.7 Depreciation Funding

In general, to incentivize providers to use depreciation funding to conserve assets, the Division shall not reduce allowable interest expense if a provider reports investment income on funded depreciation. Providers must maintain appropriate documentation to support the funded depreciation account and income earned on the account to be eligible for this relief.

However, if a provider uses funded depreciation for any purpose other than acquiring or replacing a nursing facility asset without Division approval, the Division shall offset investment income on funded depreciation for both the current cost report and may reopen settled cost reports for cause to reduce allowable interest expense and revise funded appreciation. Providers may seek Division approval to use funded depreciation to convert licensed nursing home beds to residential care or assisted living facility beds, or to construct new residential care or assisted living facility beds while concurrently reducing licensing nursing home beds.

If a provider deposits funds in a funded depreciation account without retaining sufficient working capital or resources to support ongoing operations, the Division shall not recognize the deposits as funded depreciation.

4.7.1 Depreciation Funding CMS-15 Exceptions for Replacement Reserves

Some lending institutions require funds to be set aside periodically to replace fixed assets. The periodic amounts set aside for this purpose are not allowable costs in the period when the provider expends those funds, but the Division will allow those costs when the provider withdraws and uses them either through depreciation or expense after the Division considers the usage of the funds. Because the replacement reserves are essentially the same as funded depreciation, the Division shall apply the same rules regarding interest income and expense.

If a provider leases a facility 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 the Division shall consider the replacement reserve payment as an allowable cost in the year the provider expends it. If the lessee is allowed to use a replacement reserve to replace the lessee's assets, the lessee shall not be allowed to depreciate the assets it purchases.

4.8 Advertising Expenses

Reasonable and necessary expenses for advertisements to secure necessary employees are allowable costs. Providers may purchase advertisements in newspapers or other media circulated to the public for this purpose.

4.9 Barber and Beauty Service Costs

Direct costs of barber and beauty services are not allowable costs. The fixed costs for space and equipment to provide barber and beauty services, as well as overhead associated with billing for barber and beauty services, are allowable costs.

4.10 Child Day Care Costs

Reasonable and necessary costs that a provider incurs to provide day care services to children of employees performing resident-related functions are allowable costs. If a provider receives revenue for providing day care services to employee's children, their costs will be offset by this revenue. The direct and indirect expenses related to providing day care services to children of individuals who are not employees performing resident-related functions are not allowable costs.

For the Division to accurately review and allow costs under this section, providers must accumulate all day care costs in a separate cost center. Providers must identify revenues for providing day care for employees and non-employees in separate accounts.

4.11 Community Service Activities

Providers may request permission from the Division to adjust direct identifiable incremental costs (food, direct labor, fringe benefits, and transportation) related to providing community service to

local communities, such as providing meals to vulnerable adults, adult day care, certain respite care, etc. If a provider significantly expands a program as a result of providing community services, the Division may also adjust overhead costs. Providers must maintain auditable records for all direct identifiable incremental costs associated with providing community services under this section.

4.12 Dental Services

Costs incurred for dental services for Medicaid-eligible individuals are covered under other Medicaid programs and are not allowable. However, the fixed costs for space and equipment related to providing dental services and overhead associated with billing for dental services are allowable.

4.13 Legal Costs

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

4.14 Litigation and Settlement Costs

All costs allowed under this section are non-recurring costs within the meaning of Section 4.1 of this manual.

In general, the Division will recognize attorneys' fees and other expenses incurred for litigation 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. If a provider settles a matter before a jury or bench verdict (whether or not a lawsuit has been filed), the Division will recognize one-half of the costs, including attorneys' fees, settlement award, and other expenses to the extent that the costs are related to resident care and not covered by insurance.

Litigation and settlement costs incurred in response to criminal investigations and professional licensing matters are not related to resident care for the purposes of this section and are not allowable costs.

If a provider incurs attorneys' fees and other similar expenses when challenging a decision of the Division, the Division shall allow the costs to the extent that the provider prevails, as determined by a ratio of total dollars at issue in the case to the total dollars the provider is awarded.

4.15 Motor Vehicle Allowance

The cost to operate a motor vehicle necessary to meet facility needs is allowable. If a vehicle is used for both personal and business purposes, the portion of vehicle costs associated with personal use is not allowable. If a provider fails to adequately document how much a vehicle is used for personal use and business use, the Division reserves the right to disallow all costs for the vehicle.

The Division shall allow motor vehicle costs under this section to the extent they reflect the cost of operating a similar size, mid-price vehicle in the same class.

4.16 Compensating Owners, Operators, or their Relatives

The Division shall not allow costs related to compensating an owner, operator, or their relative who claims to provide administrative functions at any facilities that employ a full-time (40 hours per week or more) nursing home administrator or assistant administrator, except as authorized in this section.

The Division may allow compensation for an owner, operator, or their relative if the provider's cost report specifically reports the function the owner, operator, or their relative performed, the number of hours worked, and the number of employees supervised. The function that the owner, or operator, or their relative performed must be unique and unduplicated by another employee.

The maximum allowable salary for an owner, operator, or their relative who claims to provide administrative functions shall be 110% percent of the average of all reported administrator salaries for Vermont nursing facilities participating in the Medicaid program for the reported fiscal year.

4.17 Post-Retirement Benefits

If CMS-15 would allow costs for benefits to retired personnel, all such costs shall be included in fringe benefits and the Division shall allocate such costs accordingly.

4.18 Related Party Expenses

If a provider pays otherwise allowable expenses to a related party, the Division shall disallow the costs, subject to the following exception. The Division may allow the costs if the provider identifies all related party expenses, the relationship the provider has with the related party, and all expenses attributable to the related party. The provider must also demonstrate that the related party expenses do not exceed the lower of the cost to the related party or the price of comparable services, facilities, or supplies that the provider could purchase elsewhere.

4.19 Revenues

If a facility reports operating or non-operating revenues related to goods or services they provide, the costs to which those 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 the costs to which the revenues correspond, the deduction shall be equal to such costs.

4.20 Travel/Entertainment Costs

Reasonable and necessary costs of meals, lodging, transportation, and incidentals incurred for purposes related to resident care are allowable. All costs that the Division determines are for the pleasure and convenience of the provider or the providers' representatives will not be allowed.

4.21 Transportation Costs

Reasonable and necessary costs for transportation, other than ambulance services for emergency transportation or for transportation home from a nursing facility, that are related to the care of residents are allowable. Transportation costs shall include the depreciation of utility vehicles, mileage reimbursement to employees when employees use their privately owned vehicles to transport residents, and any contractual arrangements for providing transportation. Transportation costs shall not be separately billed for individual residents.

Transportation costs related to residents receiving kidney dialysis shall be reported in the Ancillary cost category. All other costs allowed under this section shall be reported in the Indirect cost category.

Section 5 Reimbursement Standards

5.1 Resident Acuity Classification

The Division adopts this section of the Nursing Facility manual to comply with state law, 33 V.S.A. § 905(b)(1), which requires the Division to group residents into classes according to the similarity of their assessed conditions and needed services to incentivize facilities to admit residents that may be more costly to care for than others. To accomplish this, the Division shall operate a prospective case-mix reimbursement system.

5.1.1 Classification Process

The Department of Aging and Independent Living, Division of Licensing and Protection, shall prescribe a form for assessing residents and classifying them into groups. Providers shall self-assess their residents according to this form.

5.1.2 Categorization

Vermont Medicaid has adopted a variant of the Patient-Driven Payment Model (PDPM) adopted by the federal Centers for Medicare and Medicaid Services (CMS) for use in calculating Medicaid rates. Vermont Medicaid uses the nursing components of the PDPM model to categorize nursing home residents. The Division shall weight different categories of residents according to the table set out in Section 7.2 of this Manual.

5.2 Base Years

A Base Year shall be a calendar year from January 1 through December 31. The Division originally rebased all costs on January 1, 2007, and has rebased all costs every four years thereafter. The Division rebased nursing costs every two years thereafter. The Division rebases ancillary costs and property and related costs every year.

When rebasing, the Director of the Division may require a facility to file a special cost report covering the calendar year that is the Base Year if the facility's fiscal year does not already run from January 1 through December 31. The Division may instead use the facility's fiscal year costs, adjusted for inflation in accordance with Section 5.4 of this Manual. If the Director of the Division requires a facility to prepare and file a special cost report, the cost of doing so is an allowable cost under the Division's rules and this Manual.

5.3 Target Resident Occupancy

Vermont Medicaid has established a target occupancy rate of 80 percent. If a facility fails to maintain average resident days at or above this amount, the Division shall apply the provisions of V.D.R.S.R. § 5.7.

5.4 Inflation Adjustment

The Division adopts this section of the Nursing Facility manual to comply with state law, 33 V.S.A. § 905, which requires the Division to adjust a facility's base year rates annually by reasonable and adequate inflation factors.

On June 1 of each year, the Director shall consult the most recent available publication of the Health Care Cost Service to calculate annual inflation adjustments and rebase inflation adjustments, if necessary.

The Division shall use different inflation factors to adjust different rate components and shall weigh subcomponents of each inflation factor in proportion to the percentage of actual allowable costs

that Vermont facilities incur for each subcomponent. For example, if a cost in the Nursing Care cost component is 80 percent attributable to salaries and wages and 20 percent attributable to employee benefits, the Division shall weight these two subcomponents of the Nursing Care inflation factor at .8 and .2 respectively. The Division shall recalculate the weights for each inflation factor each time the relevant cost category is rebased.

5.4.1 Nursing Care Component Inflation

The Division shall adjust the Nursing Care rate component by an inflation factor that uses two price indices to account for estimated economic trends with respect to two subcomponents of nursing care costs: (1) wages and salaries, and (2) benefits. The price indices for each subcomponent are the wages and salaries portion of the Health Care Cost Service NHMB and the employee benefits of the NHMB respectively. The Division shall additionally adjust the rate component by one percentage point for every 12-month period, prorated for fractions thereof, from the midpoint of the base year to the midpoint of the rate year.

5.4.2 Resident Care Component Inflation

The Division shall adjust the Resident Care rate component by an inflation factor that uses four price indices to account for estimated economic trends with respect to four subcomponents of resident care costs: (1) wages and salaries, (2) benefits, (3) utilities, and (4) food and all other costs. The price indices for each subcomponent are the wages and salaries portion of the Health Care Cost Service NHMB, the employee benefits of the NHMB, the utilities portion of the NHMB, and the food portion of the NHMB respectively.

5.4.3 Indirect Component Inflation

The Division shall adjust the Indirect rate component by an inflation factor that uses three price indices to account for estimated economic trends with respect to three subcomponents of indirect costs: (1) wages and salaries, (2) benefits, and (3) all other indirect costs. The price indices for each subcomponent are the wages and salaries portion of the Health Care Cost Service NHMB, the employee benefits of the NHMB, the utilities portion of the NHMB, and the NECPI-U (all items) respectively.

5.4.4 Director of Nursing Component Inflation

The Division shall adjust the Director of Nursing rate component by an inflation factor that uses two price indices to account for estimated economic trends with respect to two subcomponents of Director of Nursing costs: (1) wages and salaries, and (2) employee benefits. The price indices for each subcomponent are the wages and salaries portion of the Health Care Cost Service NHMB and the employee benefits of the NHMB respectively.

Section 6 Base Year Cost Categories

6.1 In General

Providers should allot costs that they incur into appropriate accounts that relate to nursing care, resident care, indirect costs, director of nursing costs, property and related costs, and ancillary costs as described in this manual.

6.2 Nursing Care Costs

Allowable costs in the Nursing Care component of the rate include the actual costs of licensed personnel providing resident care who are required to follow state and federal law. These personnel include (1) registered nurses, (2) licensed practical nurses, (3) certified or licensed nurse aides, including wages for initial and ongoing nurse training as required by the 1987 Omnibus Budget Reconciliation Act, (4) contract nursing, (5) the Minimum Data Set (MDS) coordinator, and (6) fringe benefits for the personnel listed in this section, including child day care as allowed by this manual.

The costs of unlicensed staff, including bedmakers, geriatric aides, transportation aides, paid feeding and dining assistants, ward clerks, and medical records librarians, are not Nursing Care costs. The salary and related benefits of the Director of Nursing shall be excluded from the Nursing Care costs and reimbursed separately.

6.3 Resident Care Costs

Allowable costs in the Resident Care component of the rate include reasonable costs associated with expenses related to direct care, including:

a. Food, vitamins, and food supplements,
b. Utilities, including heat, electricity, sewer and water, garbage, liquid propane gas, or other required fuels,
c. Activities personnel, including recreational therapy and direct activity supplies,
d. Medical Director, Pharmacy Consultant, Geriatric Consultant, and Psychological or Psychiatric Consultant costs,
e. Counseling personnel, chaplains, art therapists, and volunteer stipends,
f. Social service workers,
g. Employee physicals,
h. Wages for paid feeding/dining assistants, for those hours that assistants are actually engaged in assisting residents with eating,
i. Fringe benefits, including child day care, for any personnel identified above, and
j. Any other items that the Director may prescribe by issuing a practice and procedure issued pursuant to subsection 1.8(d).

6.4 Indirect Costs

Allowable costs in the Indirect component include reasonable 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:

a. Fiscal services,
b. Administrative services or professional fees,

c. Plant operation and maintenance,
d. Grounds,
e. Security,
f. Laundry and linen,
g. Housekeeping,
h. Medical records,
i. Cafeteria,
j. Seminars, conferences, or other in-service training, except that tuition for college credit in a discipline related to a staff member's employment or costs of obtaining a GED are treated as fringe benefits for that staff member,
k. Dietary, excluding food,
l. Motor vehicle costs,
m. Clerical costs, including ward clerks,
n. Transportation (excluding depreciation),
o. Insurance for director and officer liability, comprehensive liability, bond indemnity, malpractice, premises liability, motor vehicles, or any other costs of insurance incurred or required in the care of residents that has not been specifically addressed elsewhere,
p. Office supplies and telephone costs,
q. Conventions and meetings,
r. EDP bookkeeping and payroll,
s. Fringe benefits for staff employed in the roles listed in this section, including child day care, and
t. Any expense not specified for inclusion in another cost category, except that:
    (1) The Director may specify that costs be reported in a different cost category in the instructions to the cost report, the chart of accounts, or by issuing a practice and procedure under V.D.R.S.R. § 1.8, and
    (2) Vermont Medicaid reimburses prescription drug costs through other programs; therefore, these costs are not allowable and shall not be included in any cost category.

6.5 Director of Nursing Costs

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

6.6 Property and Related Costs

a. Allowable costs in the Property and Related component include:
    (1) Depreciation on buildings and fixed equipment, major movable equipment, minor equipment, computers, motor vehicles, land improvements, and amortization of leasehold improvements and capital leases,
    (2) Interest on capital indebtedness,
    (3) Real estate leases and rents,

(4) Real estate taxes and property taxes,

(5) All equipment, whether it is capitalized, expensed, or rented,

(6) Fire and casualty insurance, and

(7) Amortization of mortgage acquisition costs.

b. For any proposed change in services or facility, or for a new health care project, with projected property and related costs of $250,000 or more, providers must give the Division written notice of the project no less than 60 days before commencing work on the project. The notice must include a detailed description of the project and a detailed estimate of all costs. If a provider fails to give the Division notice of a change or project as required by this section, the Division may refuse to allow the associated costs.

6.7 Ancillaries

Allowable costs in the Ancillary component include:

a. All physical, speech, occupational, respiratory, and IV therapy services and therapy supplies, excluding oxygen. Medicaid allowable costs shall be based on the cost-to-charge ratio for these services. These therapy services shall not be allowable unless:

(1) The services are provided pursuant to a physician's order,

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

(3) The services are not reimbursable by Medicare, and

(4) The provider records charges by payor class for all units of these services.

b. Medical supplies, whether or not the provider customarily records charges. For purposes of this section,

(1) "Medical supplies" includes, but is not limited to, oxygen, disposable catheters, catheters, colostomy bags, drainage equipment, trays, and tubing,

(2) "Medical supplies" does not include rented or purchased equipment, with the exception of rented or purchased oxygen concentrators, which are medical supplies.

c. Over the counter drugs. All drug costs may be disallowed if a provider commingles the costs of prescription drugs with over-the-counter drugs.

d. Incontinence supplies and personal care items. These items include adult diapers, chux and other disposable pads, and personal care items such as toothpaste, shampoo, baby powder, combs, brushes, and similar products.

e. 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 costs associated with the use of provider-owned vehicles.

f. Overhead costs related to ancillary services and supplies.

Section 7 Calculating Costs, Limits, and Rate Components

After determining which costs are allowable, the Division calculates per diem costs for each cost category, sets base year rates, and sets limits on the amount that the base year rates can rise.

7.1 Calculating Per Diem Costs

The Division calculates per diem costs for each cost category, except the Nursing Care and Ancillary cost categories, 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 that the facility would have provided had the facility operated at the minimum occupancy standard set in Section 5.3 of this manual during the cost period under review.

7.2 Nursing Care Component

7.2.1 Case Mix Weights

There are 25 case-mix resident classes. Each case-mix class has a specific case-mix weight as follows:

Group Code	Case-Mix Weight	Description
ES3	3.84	Extensive Services
ES2	2.90	Extensive Services
ES1	2.77	Extensive Services
HDE2	2.27	Serious Medical Conditions
HDE1	1.88	Serious Medical Conditions
HBC2	2.12	Serious Medical Conditions
HBC1	1.76	Serious Medical Conditions
LDE2	1.97	Serious Medical Conditions
LDE1	1.64	Serious Medical Conditions
LBC2	1.63	Serious Medical Conditions
LBC1	1.35	Serious Medical Conditions
CDE2	1.77	Complex Medical Care
CDE1	1.53	Complex Medical Care
CBC2	1.47	Complex Medical Care
CA2	1.03	Complex Medical Care
CBC1	1.27	Complex Medical Care
CA1	0.89	Complex Medical Care
BAB2	0.98	Behavioral or Cognitive Symptoms
BAB1	0.94	Behavioral or Cognitive Symptoms
PDE2	1.48	Assistance with Daily Living
PDE1	1.39	Assistance with Daily Living
PBC2	1.15	Assistance with Daily Living

Group Code	Case-Mix Weight	Description
PA2	0.67	Assistance with Daily Living
PBC1	1.07	Assistance with Daily Living
PA1	0.62	Assistance with Daily Living

7.2.2 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. After each base year, the Division of Licensing and Protection shall certify the average case-mix score for all residents of each facility to the Division of Rate Setting. In between these base year certifications, the Division of Licensing and Protection shall certify the average case-mix score of all residents at each facility for whom Medicaid pays their room and board no less than quarterly.

7.2.3 Calculating Nursing Care Costs Per Case Mix Point

The Division shall calculate each facility's Nursing Care cost per case mix point as follows:

a. The Division shall determine each provider's allowable Nursing Care costs using each facility's base year cost report.

b. The Division shall compute each facility's Standardized Resident Days by multiplying total resident days from the most recent base year by that facility's average case mix score for all residents for the four quarters of the cost reporting period under review.

c. The Division shall compute the per diem nursing care cost per case mix point by dividing total allowable Nursing Care costs by the Base Year Standardized Resident Days for that base year.

7.2.4 Nursing Care Cost Limits

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 any nursing facilities that have stopped participating in the Medicaid program at the time the limits are set, from lowest to highest. These costs shall be limited to the cost at the ninety-fifth percentile calculated using the percentile spreadsheet function. Each facility's base year Nursing Care rate per case mix point shall be the lesser of the limit in this section or the facility's actual allowable Nursing Care costs per case mix point.

7.3 Resident Care Base Year Rate

The Division shall compute Resident Care base year rates as follows:

a. The Division shall determine each provider's allowable Resident Care costs using each facility's base year cost report.

b. The Division shall calculate each facility's base year per diem allowable Resident Care costs by dividing the base year total allowable Resident Care costs by total base year resident days.

c. The Division shall array all nursing care facilities' allowable base year per diem Resident Care costs, excluding those for state nursing facilities and any nursing facilities that have stopped participating in the Medicaid program at the time the limits are set, from lowest to highest, then identify the median.

d. The per diem limit shall be the median plus twenty-five percent.

e. Each facility's base year Resident Care per diem rate shall be the lesser of the limit set in subsection (d) of this section or the facility's actual base year per diem allowable Resident Care costs.

7.4 Indirect Base Year Rate

The Division shall compute Indirect base year rates as follows:

a. The Division shall determine each provider's allowable Indirect costs using each facility's base year cost report.

b. The Division shall calculate the base year per diem allowable Indirect costs for each facility by dividing the base year total allowable Indirect costs by total base year resident days.

c. The Division shall array all nursing care facilities' allowable base year per diem Indirect costs, excluding those for state nursing facilities and any nursing facilities that have stopped participating in the Medicaid program at the time the limits are set, from lowest to highest, then identify the median.

d. The Division shall set the per diem limit 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 115 percent of the median.

e. Each provider's base year Indirect per diem rate shall be the lesser of the limit in subsection (d) of this section or the facility's actual base year per diem allowable costs.

7.5 Director of Nursing Base Year Rate

The Division shall compute each facility's Director of Nursing base year per diem rates as follows:

a. The Division shall determine each provider's allowable Director of Nursing costs using each facility's base year cost report.

b. The Division shall calculate each facility's base year per diem allowable Director of Nursing costs by dividing the base year total allowable Director of Nursing costs by total base year resident days.

c. There shall be no limit on Director of Nursing per diem costs besides the basic requirement that these costs must be allowable.

7.6 Ancillary Services Rate

The Division shall compute each facility's Ancillary per diem rates as follows:

a. The Division shall determine each facility's Medicaid ancillary costs.

b. The Division shall calculate each facility's Ancillary rate using each facility's most recently settled cost report as follows:

(1) The Division shall calculate costs for therapy services per diem, including IV therapy, by dividing allowable Vermont Medicaid costs by the number of related Vermont Medicaid resident days less Vermont Medicaid hold days.

(2) The Division shall calculate dialysis transportation costs per diem by dividing the allowable costs for Vermont Medicaid residents by the number of Vermont Medicaid resident days less Vermont Medicaid hold days.

(3) The Division shall calculate costs for medical supplies, over the counter drugs, incontinent supplies, and personal care items per diem by dividing allowable costs for those services by total resident days, less hold days.

c. If the Division determines that a facility's Ancillary per diem rate should change as a result of its analysis, the Division shall implement that change at the time of the first quarterly case mix rate recalculation after the cost report is settled.

7.7 Property and Related Per Diem Costs

The Division shall compute each facility's Property and Related per diem rates as follows:

a. Using each facility's most recently settled annual cost report, the Division shall determine each facility's total allowable Property and Related costs.

b. The Division shall calculate the facility's per diem Property and Related rate by dividing allowable Property and Related costs by total resident days.

c. If the Division determines that a facility's Property and Related per diem rate should change as a result of its analysis, the Division shall implement that change at the time of the first quarterly case mix rate recalculation after the cost report is settled.

7.8 Total Per Diem Rate

7.8.1 Nursing Facility Rate Components

The total Nursing Facility 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. Ancillary, and

g. Adjustments (if any).

7.8.2 Calculating the Total Rate

The Division shall identify all the rate components listed in Section 7.8.1 and adjust the components in accordance with Inflation Factors identified in this manual. The Division shall add all of the rate components together to arrive at the total per diem rate.

7.8.3 Updating Rates for Change in Case-Mix Score

a. The Division shall update the Nursing Care rate component, including any rate adjustment that reimburses for Nursing Care costs, of each facility's rate quarterly, on the first day of January, April, July, and October, to reflect changes in the average case-mix score of the facility's Medicaid residents.

b. The Division shall calculate the updated Nursing Care rate component as follows:

(1) The Division shall divide the Nursing Care rate component, including any rate adjustment that reimburses for Nursing Care costs, 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 per case mix point is multiplied by the new average case mix score. This product is the new Nursing Care rate component.

7.8.4 Case-Mix Scores from July 1, 2024, through March 31, 2025

a. This section is effective July 1, 2024, and shall terminate on March 31, 2025.

b. The Division shall phase in the process described in Section 7.8.3 of this Manual from July 1, 2024, through March 31, 2025. To the extent this section conflicts with Section 7.8.3 of this Manual, this section supersedes that section.

c. Specifically, in Section 7.8.3(b)(1), the Division shall use a weighted average case-mix score rather than the reported average case-mix score. The Division shall calculate this weighted average case-mix score by averaging the facility's last average case-mix score calculated under the Resource Utilization Group IV (RUG-IV) methodology with the current average case-mix score using the following weights:

- For rates set on July 1, 2024, the last average case-mix score calculated under the RUG-IV methodology shall constitute 75% of the calculated average score.
- For rates set on October 1, 2024, the last average case-mix score calculated under the RUG-IV methodology shall constitute 50% of the calculated average score.
- For rates set on January 1, 2025, the last average case-mix score calculated under the RUG-IV methodology shall constitute 25% of the calculated average score.

7.9 Quality Awards Program

The Division may make awards to facilities that provide superior care in a cost-effective manner under this section.

7.9.1 Standards

The Division shall base any awards under this section on objective standards of:

a. quality, including resident satisfaction surveys, to be determined by the Department of Disabilities, Aging, and Independent Living, and

b. cost efficiency, to be determined by the Division in accordance with a practice and procedure that the Division shall issue.

7.9.2 Purpose of Payments

Providers must use supplemental payments under the Quality Awards program to enhance the quality of care they provide to Medicaid-eligible residents. In determining how best to accomplish this goal, providers must consult with the facility's Resident Council. If a provider fails to comply with this section, the Division may recoup the supplemental payments when setting future per diem rates.

7.9.3 Methodology for Distribution

a. Vermont Medicaid shall make quality incentive payments 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 5 facilities and $125,000.

b. The Division shall distribute the pool among the qualifying facilities, awarding each qualifying facility a share of the pool based on the ratio of the facility's Medicaid days to the total Medicaid days for all the qualifying facilities.

7.9.4 Award Process and Criteria

a. The Division shall apply the award criteria to facility data up to March 31 each year to determine eligibility for the awards, which the Division shall present before the end of the rate year. Facilities must participate in Vermont Medicaid and meet all of the award criteria.

b. The Department of Disabilities, Aging, and Independent Living shall rank all eligible facilities according to their quality of care. The five facilities with the highest quality of care will receive an award. If, based on the basic criteria, there are ties that would cause more than five facilities to be equally qualified, the tied facilities will be ranked according to the efficiency criteria to determine those facilities that will receive an award.

c. *Basic criteria*. The basic criteria are as follows:

   (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 and may not receive a deficiency of "D" level in each of the general categories of Quality of Care, Quality of Life, or Resident Rights.

   (2) DAIL has not substantiated a complaint in the two most recent surveys related to quality of care, quality of life, or residents' rights.

   (3) The facility must participate in a statewide quality improvement campaign approved by DAIL.

   (4) Resident satisfaction surveys must record a result above the statewide average.

   (5) The facility must receive a fire safety deficiency score of 5 or less with scope and severity less than "E" level in the most recent full survey.

d. *Efficiency criteria*. To resolve a tie under subsection (b) of this section, the Division shall determine each facility's allowable cost per day using each facility's most recently settled Medicaid cost report. The Division shall calculate the facility's cost per day using actual resident days for the same fiscal period. The Division shall resolve the tie in favor of the facility that had a lower cost per day.

Section 8 Special Rates

In rare and exceptional circumstances, an individual may be extremely difficult to place in appropriate long-term care settings. In these rare and exceptional circumstances, providers may apply for a special rate for that individual in accordance with this section.

8.1 Individuals with Unique Physical Conditions

A special rate under this section is available subject to the conditions in the following subsections.

8.1.1 Required Findings

Before Vermont Medicaid approves a special rate under Section 8.1, the following findings must be made.

a. The Commissioner of the Department of Vermont Health Access, in consultation with that Department's Medical Director and the Director of DAIL's Adult Services Division or the ASD Director's designee, 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 the individual's needs,

b. The Division of Rate Setting, in consultation with the Commissioner of DVHA and the Commissioner of DAIL, must determine that the special rate that the Division has calculated under Section 8.1.3 is reasonable for the services provided.

8.1.2 Plan of Care

a. Providers must submit a plan of care for the individual to the DVHA Medical Director and the DAIL Adult Services Director or the ASD Director's designee before they accept the individual for placement.

b. Providers must submit an updated plan of care for the individual at least every six months, or more frequently if there is a significant change in the resident's physical condition.

c. The DVHA Medical Director and the DAIL Adult Services Division Director must approve the plan of care and any updated plan of care.

d. The Division shall use the DVHA Medical Director and DAIL Adult Service Division Director's approval as a basis for determining whether a special rate should be granted, continued, or revised.

8.1.3 Calculating the Rate

a. The Division shall set a per diem rate based on the budgeted allowable cost for the individual's plan of care. The per diem rate shall be exempt from any limits imposed elsewhere in this manual.

b. The Division may, from time to time, revise the special rate to reflect significant changes in the resident's assessment, care plan, and costs of providing care. The Division may revise the special rate prospectively, retroactively, or both based on the actual allowable costs of providing care to the resident.

c. Special rates set under Section 8.1 shall not affect the facility's normal per diem rate.

(1) Any resident who receives a special rate under Section 8.1 shall not be included when the Division calculates a facility's average case-mix score.

(2) The Division shall include the resident's days of care in a facility's Medicaid days and total resident days when determining a facility's per diem rates and limits.

(3) Providers receiving a special rate under Section 8.1 shall track the total costs of providing care to the resident and shall self-disallow the incremental cost of providing that care on cost reports that cover the period during which the facility receives Medicaid payments for services to the resident.

8.2 Individuals with Unique Mental and Emotional Conditions

A special rate is available under this section is available subject to the conditions in the following subsections. The special rate is available on a prospective basis only.

8.2.1 Required Findings

The Commissioner of the Department of Mental Health or their designee must determine that a resident or prospective resident has a documented history of severe behaviors that prevent them from being placed in a nursing home. The resident must exhibit behaviors that would be significantly more challenging than those of the general nursing facility population.

8.2.2 Plan of Care

a. Providers must submit a plan of care for the individual to the Department for Mental Health and the DAIL Adult Services Division before they accept the individual for placement.

b. The DMH Commissioner and DAIL's Division of Licensing and Protection must approve the plan of care and any updated plan of care before the individual is placed.

c. After the individual is placed at the facility, the facility must document 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, or that the transferred person's behavior has abated because of supports provided by the nursing home. The facility must submit this documentation to DAIL's Division of Licensing and Protection no less than annually.

8.2.3 Available Rates

The special rate that the facility shall receive shall consist of the current per diem rate for the facility as calculated under the Division's rules and this manual, plus a monthly supplemental incentive payment. Vermont Medicaid makes three levels of supplemental payments available for the care of residents that meet the eligibility criteria in Section 8.2. DAIL's Commissioner shall determine the three levels of payments that are available. Facilities shall receive one of the three levels based on the severity of the resident's condition and the resources needed to provide care.

8.3 Rates for Individuals in the Custody of the Department of Corrections

Vermont Medicaid may grant an incentive payment for a facility to care for an individual who is transferred directly from the custody of the Department of Corrections, whether serving as an inmate at an institution or on probation or parole. In general, the special rate shall be 150 percent of a nursing facility's ordinary Medicaid rate. Facilities must apply for this special rate on forms prescribed by the Division. Facilities must annually recertify that the individuals for which they receive an incentive payment under this section continue to be in the custody of the Department of Corrections.