

# 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 16, 2020.

I approve the contents of this filing entitled:

Private Nonmedical Institution Rate Setting Methodology in Response to COVID-19

 \_\_\_\_\_, on 04/09/2020  
(signature) (date)

Printed Name and Title:

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

- 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)

RECEIVED BY: \_\_\_\_\_  
**RECEIVED**  
APR - 9 2020  
BY: \_\_\_\_\_

Emergency Rule Coversheet

1. TITLE OF RULE FILING:

Private Nonmedical Institution Rate Setting Methodology  
in 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).

PLEASE SUMMARIZE THE REASON FOR THE EXEMPTION:

In existing rule V.P.N.M.I.R. § 2.5(f), an exemption  
for personal information about a resident to protect  
their privacy and in accordance with Health Insurance

Emergency Rule Coversheet

Portability and Accountability Act (HIPAA) (45 CFR part 160).

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. EXPLANATION 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):

During the COVID-19 State of Emergency, the rate setting methodology for Crisis/Stabilization Programs, per V.P.N.M.I.R. § 7.5, will be applied to all Vermont Medicaid private nonmedical institutions (PNMIs) beginning with the March reimbursement period for which payment will be issued on or after April 9, 2020.

9. EXPLANATION OF WHY THE RULE IS NECESSARY:

The emergency rule is necessary to provide financial stability to private non-medical institutions (PNMIs) during the COVID-19 State of Emergency (COVID-19 Response). During the COVID-19 Response, PNMIs are likely to face financial instability as a result of residents being transferred to other facilities or being sent home to facilitate social distancing or as a result of staffing shortages. Fluctuating occupancy levels are expected to result in unreliable revenue streams for the PNMIs impacted by the COVID-19 Response. Without reliable revenue, some PNMIs could be forced to close resulting in reduced services available

## Emergency Rule Coversheet

to youth and young adults both during the COVID-19 Response and after. The emergency rule provides financial relief to the PNMI programs during the COVID-19 emergency by ensuring a predictable stream of Medicaid revenue.

Under the current rate setting methodology, PNMI reimbursement is provided on a per diem basis. The Medicaid per diem rate is established prospectively for each program based on its historical allowable costs divided by base year resident days, subject to minimum occupancy requirements. PNMI program Medicaid revenue is driven by the number of Medicaid residents; if the Medicaid census drops, then Medicaid revenue will drop proportionally as well.

### 10. EXPLANATION OF HOW THE RULE IS NOT ARBITRARY:

On March 16, 2020, the Governor proclaimed an all-hazard State of Emergency due to the COVID-19 outbreak. Residents of PNMI have been moved out of PNMI as a direct result of the COVID-19 outbreak which has resulted, and will continue to result in, fluctuating and decreased occupancy levels for many PNMI. The emergency rule narrowly addresses these issues, allowing PNMI to continue to receive a Medicaid rate covering their base year costs despite occupancy fluctuations.

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

Private nonmedical institutions 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 PNMI are suffering due to the COVID-19 outbreak. The revised rate will provide a steady source of income to these important 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).

Emergency Rule Coversheet

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: 04/09/2020

17. EMERGENCY RULE WILL REMAIN IN EFFECT UNTIL

*(A DATE NO LATER THAN 180 DAYS FOLLOWING ADOPTION OF THIS EMERGENCY RULE):*

10/05/2020

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).

Private nonmedical institution

Medicaid

Coronavirus

COVID-19



**State of Vermont**  
**Agency of Administration**  
**Office of the Secretary**  
Pavilion Office Building  
109 State Street  
Montpelier, VT 05609-0201  
[www.aoa.vermont.gov](http://www.aoa.vermont.gov)

[phone] 802-828-3322  
[fax] 802-828-3320

*Susanne R. Young, Secretary*

## MEMORANDUM

**TO:** Jim Condos, Secretary of State

**FROM:** Susanne R. Young, Secretary of Administration      Bradley L Ferland  
Digitally signed by Bradley L Ferland  
Date: 2020.04.09 13:59:58 -04'00'

**DATE:** April 9, 2020

**RE:** Emergency Rule Titled 'Private Nonmedical Institution Rate Setting Methodology in Response to COVID-19' by the Agency of Human Services, Department of Vermont Health Access, Division of Rate Setting

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The use of rulemaking procedures under the provisions of 3 V.S.A. §844 is appropriate for this rule. I have reviewed the proposed rule provided by the Agency of Human Services, Department of Vermont Health Access, Division of Rate Setting, and agree that emergency rulemaking is necessary.

# 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:**

Private Nonmedical Institution Rate Setting Methodology  
in 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# 14-007

CVR 13-010-002 - Methods, Standards and Principles for  
Establishing Payment Rates for Private Nonmedical  
Institutions Providing Residential Child Care Services  
(V.P.N.M.I.R.) § 7

Effective September 8, 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:

Private Nonmedical Institution Rate Setting Methodology  
in 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:*

Private nonmedical institutions

### 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.

Economic Impact Analysis

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 small PNMI's by providing reliable monthly reimbursement for services provided to Vermont children and young adults who are residents of the program.

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 rate methodology does not change the burden of compliance, but only requires PNMI programs to submit census five days after the end of the month rather than by the 15<sup>th</sup> of the month.

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 reimbursement to these vital service providers could fluctuate widely and could result in some PNMI's suffering severe financial hardship including insolvency. Without additional financial support, these programs could close which would be harmful 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 described 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

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### 1. TITLE OF RULE FILING:

Private Nonmedical Institution Rate Setting Methodology  
in 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.

Environmental Impact Analysis

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:**

Private Nonmedical Institution Rate Setting Methodology  
in 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:**

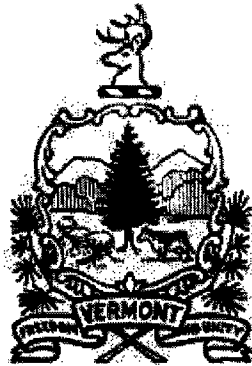
The emergency rule will be posted on DVHA's website and  
will be sent electronically to each impacted PNMI.

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 response to requests from  
the placement authorizing departments including the  
Department of Mental Health, the Department for  
Children and Families, and the Agency of Education who  
are in regular contact with all Medicaid PNMI and are  
responsible for placement of residents in the PNMI. The  
Vermont Coalition of Residential Programs (VCORP) was  
notified of the proposed change at their April 2, 2020

meeting by a representative from the Vermont Department of Mental Health.

STATE OF VERMONT  
AGENCY OF HUMAN SERVICES  
DIVISION OF RATE SETTING



**METHODS, STANDARDS AND PRINCIPLES FOR  
ESTABLISHING PAYMENT RATES FOR  
PRIVATE NONMEDICAL INSTITUTIONS  
PROVIDING RESIDENTIAL CHILD CARE SERVICES**

**SEPTEMBER 2015**

**EMERGENCY RULE**

**APRIL 9, 2020**

{Amendments to the existing rule are underlined.}

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**Private Non-Medical Institutions**

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## **1 GENERAL PROVISIONS**

### **1.1 Scope and Purpose**

These rules apply to all private nonmedical institutions that are participating in the Vermont Medicaid program, providing services in licensed residential treatment programs and that have a contract with at least one of the placement authorizing departments (PAD) as defined in Section 13 of these rules. The purpose of these regulations is to establish the methods, standards and principles used to determine and calculate payment rates for these services consistent with efficiency, economy and quality of care, in compliance with Title XIX of the Social Security Act, and to ensure that no Medicaid reimbursement is made for non-covered services. These rules identify those costs that are allowable as the basis for setting rates.

### **1.2 Authority**

These rules are promulgated pursuant to 33 V.S.A. §1901(a) to meet the requirements of 33 V.S.A. Chapter 3, 42 U.S.C. §1396a(a)(30), and 42 C.F.R. Part 434, Subpart B (relating to private nonmedical institutions.)

### **1.3 General Description of the Rate Setting System**

Payment rates are established prospectively for each program based on historic allowable costs of the program. A per diem rate is established for each major category of service provided by these facilities: medical treatment; room, board and supervision; and education. The approved rate is based on a funding application and financial state-

ments submitted to the Division by the provider.

### **1.4 Requirements for Participation in Medicaid Program**

To be eligible to participate in the Medicaid program and receive Medicaid reimbursement, a program must be licensed by the Department for Children and Families' Residential Licensing and Special Investigations Unit, have an approved Medicaid provider agreement with Department of Vermont Health Access, and have an approved contract with at least one of the placement authorizing departments (PAD) as defined in Section 13 of these rules.

### **1.5 Prior Authorization of Placement**

Prior authorization by a PAD is required for all admissions to residential treatment programs for which payment is anticipated from the State or a political subdivision thereof.

### **1.6 Responsibilities of Owners**

The owner of a residential treatment program shall prudently manage and operate a program of adequate quality to meet its residents' needs and comply with the rules and regulations or other requirements and standards of the Agency of Human Services and the Agency of Education, including the Department for Children and Families' Licensing Regulations for Residential Treatment Programs. Neither the issuance of a per diem rate, nor final orders made by the Director or a duly authorized representative of a PAD shall in any way relieve the owner of such a program from full responsibility for such compliance.

## **1.7 Duties of the Owner**

The owner of a residential treatment program participating in the Medicaid program, or a duly authorized representative shall:

(a) Comply with the provisions of subsections 1.4, 1.5 and 1.6 setting forth the requirements for participation in the Medicaid program.

(b) Submit master file documents, funding applications and supporting documentation in accordance with the provisions of subsections 3.1 and 3.2 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 by an independent public accountant in conformance with Generally Accepted Auditing Standards (GAAS), including a sub-schedule, when applicable, showing total PNMI revenues and costs, including allocated costs, and showing PNMI net program revenues.

(e) Report to the Division within 30 days when there has been a change of ownership or ownership structure of the program.

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

## **1.8 Powers and Duties of the Division of Rate Setting and the Director**

(a) The Division shall establish and certify to the appropriate PADs per diem rates for payment to providers of residential child care services on behalf of residents eligible for assistance under the Social Security Act.

(b) The Division may require any residential treatment program 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 rate setting function.

(c) The Division may examine books and accounts of any program and related parties or organizations.

(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 the general representative of each residential treatment program 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) The Division shall prescribe procedures and forms to be used in the completion of time studies.

(h) The Division, in consultation with the PADs, shall establish and certify the occupancy standards to be used in the rate setting process.

(i) 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 requirements of these rules shall be construed as a waiver of such requirements in the future. The obligations of the provider with respect to performance shall continue, and the Division shall not be estopped from requiring such future performance.

(j) Neither the Division nor the PADs shall be bound in determining the allowability of reported costs, in ruling on applications for rate adjustments, or in making any other decision relating to the establishment of rates, by any prior decision. Such decisions shall have no precedential value. Principles and decisions of general applicability shall be issued as a Division practice or procedure, pursuant to Section 1.8(d).

(k) Notwithstanding any other provisions of these rules, the Division may, at the discretion of the Director, establish and certify per diem rates pursuant to these rules for licensed Vermont residential treatment programs for the use of other states placing children in the program when the program is not currently contracting with a Vermont PAD to place children.

**1.9 Powers and Duties of the Department for Children and Families, Department of Mental Health, Department of Disabilities, Aging and Independent Living, Department of Health's Division of Alcohol and Drug Abuse Programs and Agency of Education and other PADs relating to Rate Setting**

(a) The PADs shall establish and enforce billing and payment procedures.

(b) The PADs reserve the right to review, modify, accept or reject any adjustment requests made in accordance with Sections 8 and 9 of these rules.

(c) The Department for Children and Families is responsible for licensing standards and enforcement. The PADs are responsible for program standards, placement procedures, and contract enforcement.

**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 ad-

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.

(d) Filing shall be deemed to have occurred when a document is received and date-stamped as received at the office of the Division of Rate Setting 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 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 of Rate Setting**

(a) A provider 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 executive officer of the PNMI, 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**

These rules are effective from July 25, 1995 (as amended August 1, 1999, August 1, 2003, August 5, 2008, February 24, 2014 and September 8, 2015).

## **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 from 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 standards governing the performance of their employees engaged in purchasing goods and services. Such standards shall provide, to the maximum extent practical, open and free competition among vendors.

(b) Any purchase that fails to satisfy the prudent buyer principle in CMS

Publication 15 §2103 is subject to a disallowance.

### **2.3 Cost Allocations**

(a) Certain costs which cannot correctly be identified as entirely belonging to the PNMI or to a single service category within the PNMI must be allocated to each program and service category in a manner that reflects the appropriate share of costs for each eligible category.

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

(1) Salaries/wages - Time reporting identifying and dividing time between that spent working for the PNMI and time working in other programs operated by the central office.

(2) Employee Benefits - shall be allocated to reflect the actual allowable expenses for the employees identified as directly working in each program(s) (worksheets are required to support the actual expense allocation method) or the portion of total agency employee benefit expenses that equals the ratio of gross salary and wages for the particular program(s) to the total gross salary and wages for the agency.

(3) Facility costs and costs of operation and maintenance - may be allocated on the basis of the square footage dedicated to the PNMI program and within the PNMI program. Facilities must provide a floor plan and square footage calculation supporting the allocation. If allocation by square footage is not feasible, then an alternative method shall be established by agreement between the provider and the Division.

(4) Food and Laundry - For the PNMI program, allocated on the ratio of PNMI residents to total residents.

(c) Only such costs as are determined by the Division to be reasonable pursuant to these rules shall be allocated to the PNMI program.

#### **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, medical, and statistical records, to substantiate the data reported on the funding application and on prior year's funding applications and shall, upon request, make these records available to authorized representatives of the Vermont Agency of Human Services and the United States Department of Health and Human Services.

(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 charge 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 retain all such records for at least four years after final payment is received and all pending matters are closed.

(d) The Division shall keep all funding applications, supporting documentation submitted by the provider, correspondence, workpapers and other analyses supporting summaries of findings or other decisions for at least four years after final payment is made and all pending matters are closed.

(e) An additional retention period is required if an audit, litigation, or other legal action involving the records is started before or during the original four-year period. The provider and Division shall retain all records which are in any way related to such action until the matter has terminated and any applicable appeal period has passed.

(f) Pursuant to 1 V.S.A. §317(b), financial records filed with the Division are public records, except for records containing material which would reveal personal information about a resident.



**3 FINANCIAL REPORTING**

**3.1 Master File**

Providers shall submit the following documents for the purpose of establishing a Master file for each facility in the Vermont Medicaid program:

- (a) Description of current ownership structure, including copies of the articles of incorporation and bylaws,
- (b) description of plant layout,
- (c) current list of the board of directors,
- (d) personnel policies, and
- (e) such other documents or information as the Director may require.

**3.2 Funding Application and Financial Reporting**

- (a) Funding applications and supporting documentation for services provided by these facilities shall be reported on forms prescribed by the Director pursuant to Section 1.8.
- (b) The funding application must include the certification page signed by the owner or the program's representative, if authorized in writing by the owner.
- (c) The original signed funding application must be submitted to the Division. The original document must bear an original signature. The funding application must also be submitted to the Division in electronic format as prescribed by the Director.

(d) A provider must submit audited financial statements with the funding application, including a sub-schedule, when applicable, showing total PNMI revenues and costs, including allocated costs, and showing PNMI net program revenues.

(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, including, but not limited to:

- (1) current program narrative including description of treatment milieu,
- (2) depreciation schedule,
- (3) post-audit adjusted trial balance,
- (4) list of all related parties to the program and disclosure of transactions with related parties,
- (5) chart of accounts with account descriptions
- (6) schedules for amortization of long-term debt and depreciation of fixed assets,
- (7) list of vehicles used by the program along with a vehicle mileage summary, including beginning and ending odometer reading for the year and percentage of personal use,
- (8) list of buildings used by the program, including a description of the purpose of each building and information about whether each building is owned or leased,

(9) schedule of employee benefits, which includes the total cost of each benefit compared to total salaries,

(10) copies of all contracts with consultants and contractors for services provided to the PNMI program equal to and greater than \$5,000 and

(11) any updated documents or changes to documents submitted as part of the program's master file pursuant to section 3.1.

(f) If before the draft findings are issued, the provider has been specifically requested to provide certain information or materials pursuant to paragraph (e), and has failed to do so, such information or materials will not be admissible in any subsequent appeal taken pursuant to Section 12.

### 3.3 Adequacy and Timeliness of Filing

(a) The funding application and requested supporting documentation must be filed with the Division on a schedule to be prescribed by the Director.

(b) The Division may reject any funding application which does not meet these rules. In such a case, the funding application shall be deemed not filed, until refiled and in compliance.

(c) Extensions for filing of the funding application and requested supporting documentation beyond the prescribed deadline must be requested as follows:

(1) All requests for extension of time to file a funding application and supporting documentation must be in writing, on a form prescribed by the

Director, and must be received by the Division of Rate Setting prior to the filing deadline. The provider must clearly explain the reason for the request and specify the date on which the Division will receive the information.

(2) 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 an accountant or funding application preparer engaged in other work.

(d) When rate setting is delayed because the funding application and supporting documentation are incomplete or untimely, or requested information is not provided in a timely manner, the rate for the previous rate year will remain in effect. The new rates will take effect from the first day of the month following the Division's final order when such order results in an increase in the per diem rate. Final orders resulting in a decrease in the per diem rate, will take effect from the first day of the rate period.

### 3.4 Review of Funding Applications by Division

(a) Desk Review

(1) The Division shall perform a desk review on each funding application submitted.

(2) The desk review is an analysis of the provider's funding application 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 setting the rate without an on-site audit or determining the extent to which an on-site audit verification is required.

(3) Desk reviews shall be completed within nine months after receipt of an acceptable funding application filing, except in unusual situations, including but not limited to, delays in obtaining necessary information from a provider. Difficulties in obtaining necessary information in a timely fashion may result in delays in completion of the reviews and in the setting of rates.

(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 desk review.

**(b) On-site Audit**

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

(2) The Division may also reopen and audit prior years' settled funding applications if there is evidence and/or complaints of financial irregularities at the program.

(3) 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 Section 12.

**3.5 Settlement of Funding Applications**

A funding application 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 12.3 of these rules.

**4 DETERMINATION OF ALLOWABLE COSTS**

**4.1 Incorporation of Provider Reimbursement Manual**

In determining the allowability or reasonableness of cost 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 Publication 15, formerly known as HCFA-15), which is hereby incorporated by reference. If neither these regulations nor CMS Publication 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

(a) To be allowable, a cost must satisfy criteria, including but not limited to the following:

(1) The cost is ordinary, reasonable, necessary and related to the direct care of residents.

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

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

(b) Allowable costs include those costs incurred for the provision of resident services and equipment used in the provision of such services, including

(1) direct qualified staff salaries and benefits,

(2) other direct program costs,

(3) direct program administrative costs and

(4) indirect allocated administrative (central office) costs.

(c) An unallowable cost is one which is not incurred for resident services, related administrative services, common or joint program objectives, or is determined to be unreasonable, unnecessary or duplicative.

## 4.3 Preapproval by PADs

Preapproval is encouraged for providers anticipating a significant increase in program expenses. Providers should obtain pre-approval from the Division, in

consultation with the PADs, before making commitments to any significant increase in expenditures in the current approved program costs or future allowable costs, since such increase may affect the suitability of the program and/or the ability of the PADs to continue to purchase the program services. Preapproved increases will not be subject to the cap limitation pursuant to subsections 7.4(b) and 7.5(c).

## 4.4 Non-Recurring Costs

Any reasonable and resident-related, non-capital cost that would increase the approved costs by two percent and is not expected to be a recurring cost in the ordinary operation of the facility, may be designated a "Non-Recurring Cost". A non-recurring cost shall be capitalized and amortized for a period of three years.

## 4.5 Property and Related Costs

Property and related costs include:

(a) depreciation on buildings and fixed equipment, motor vehicle, land improvements and amortization of leasehold improvements and capital leases.

(b) interest on capital indebtedness,

(c) real estate leases and rents,

(d) real estate/property taxes, or payments in lieu of property taxes, provided that they are legal obligations of the provider and do not exceed the amount of property taxes that would have been payable if the property were subject to property taxation.

(e) equipment rental,

(f) fire and casualty insurance,

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(g) amortization of mortgage acquisition costs and non-recurring costs, and

(h) repairs and maintenance.

### **4.6 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 program.

(2) Interest expense shall be reduced by realized investment income, with the exception of investment income on funded depreciation, pursuant to subsection 4.9.

(c) The Provider must have a legal obligation to pay the interest.

(d) "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 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:

(i) 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.

(ii) The costs are no higher than the rate charged by commercial lending institutions at the inception of the loan.

(e) Other costs may be included in loans where the interest is recognized by the Division. These costs include points and costs for legal and accounting fees, and discounts on debentures and letters of credit.

(f) In refinancing of indebtedness the provider must demonstrate that the costs of refinancing will be less than the allowable costs of the current financing. Costs of refinancing may include accounting fees, legal fees and debt acquisition costs related to the refinancing. The 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.

(g) Interest is not allowable with respect to any capital expenditures in property, plant or equipment related to resident care which requires preapproval pursuant to subsection 4.3, if the necessary approval has not been granted.

### **4.7 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 the cost or fair market value. Cost includes:

(1) purchase price,

(2) sales tax, and

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

(c) 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 above.

(d) 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 4.8.

#### **4.8 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 estimated useful life of an asset shall be determined 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.

#### **4.9 Funding of Depreciation**

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.

(a) As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense or as applied revenue if it meets the relevant requirements of CMS Publication 15.

(b) The provider must maintain appropriate documentation to support the funded depreciation account and interest earned to be eligible for this provision.

#### **4.10 Leasing Arrangements for Property, Plant and Equipment**

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

(a) Rental expense on facilities and equipment leased from a related organization will be limited to the Medicaid allowable interest, depreciation, insurance and taxes for the year under review, or the price of comparable services for 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

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had it purchased or retained legal title to the asset, such as interest on mortgage, taxes, insurance and depreciation.

### **4.11 Legal and Litigation Costs**

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

(b) Litigation costs related to criminal or professional practice matters are not allowable.

(c) 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 by the ratio of total dollars at issue in the case to the total dollars awarded to the provider, subject to the non-recurring costs provision, Subsection 4.4.

### **4.12 Compensation of Owners, Operators, or their Relatives**

(a) Facilities that have a full-time (40 hours per week minimum) executive director and/or assistant director, 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 be limited to the following:

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

(2) The unduplicated functions actually performed.

(3) The hours actually worked and the number of employees supervised.

### **4.13 Management Fees and Central Office Costs**

(a) Management fees, central office costs and other costs incurred by a program for similar services provided by other entities shall be included in the general and administrative cost classification. These costs are subject to the provisions for allowable costs, allocation of costs and related party transactions contained in these rules and may include property and related costs incurred for the management company. These costs are allowable only to the extent that such costs would be allowable if the PNMI facility provided the services for itself.

(b) Management fees will not be allowed for any individual owner or employee of a program or for any company owned or partially owned by any individual owner or employee of a program. However, if any individual owner or employee of a program receives management fees in lieu of salary or other compensation, the Division will apply the provisions of subsection 4.21 to impute a reasonable amount of compensation that may be allowed for PNMI reimbursement for the individual owner or employee. No consulting costs or any other form of compensation shall be allowed in addition to the imputed allowable salary amount.

#### **4.14 Advertising and Public Relations**

The following costs are not allowable:

(a) Advertising costs, other than those advertising expenses which are reasonable and necessary to recruit necessary qualified employees.

(b) Costs incurred for services, activities and events that are determined by the Division to be for public relations or fund raising purposes.

#### **4.15 Bad Debts, Charity, and Courtesy Allowances**

Bad debts, charity and courtesy allowances are not allowable costs.

#### **4.16 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 are the actual cost to the related party without any markup or any additional negotiated fees. The Division may require 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, including the related party audited financial statements.

#### **4.17 Applied Revenues**

Where a program or central office of the program reports revenues other than those received from per diem rates, these revenues shall be applied to reduce the allowable direct program costs or central

office allocation according to the following provisions.

(a) Investment Income - With the exception of income on funded depreciation allowed pursuant to subsection 4.9, and to the extent that interest expense is allowable, interest or investment income earned by the PNMI programs or central office will be applied against the program or central office costs when calculating the total allowable program costs.

(b) Restricted Contributions and Grant Income - Contributions which are grant income or restricted by the original donor will be applied against the PNMI direct program cost or central office allocation to the extent that the costs for that program or central office projects costs are payable from that revenue source. Restricted revenues generated through fund raising campaigns or events will be reduced by the costs incurred in raising these funds (including such otherwise unallowable expenses as advertising and public relations) before being applied against reported costs.

(c) Unrestricted Contributions - In general, contributions and donations which are not restricted by the donor will not be applied against the total allowable program costs.

#### **4.18 Travel/Entertainment Costs**

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



**4.19 Transportation Costs**

Costs of transportation incurred, other than ambulance services covered pursuant to the Vermont Medicaid Covered Services Rules, that are necessary and reasonable for the care of residents are allowable. Such costs shall include depreciation of 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. Providers shall keep vehicle mileage logs and other similar records to track program costs for transportation.

**4.20 Costs for New Programs and Start-Up Costs**

(a) Reimbursement for new programs may be based on budget cost reports submitted to the Division. The Division may periodically review and revise the budgeted start-up costs and rate for a program based on the actual operating costs and occupancy of the program.

(b) The PADs may authorize reimbursement for pre-opening start-up cost for new programs. Application for approval of such reimbursement should be made before the expense is incurred. Eligible costs may include, but are not limited to capital expenditures, supplies, staffing and training costs. Reimbursement may be made by lump-sum payments or by the addition of the start-up costs to the program's approved budget for its first year of operation.

**4.21 Compensation Limitations**

(a) Allowable compensation for any reported salary amounts on the funding application, including indirect or allocated salary amounts, shall be limited to a factor of seven times the lowest paid direct care non-allocated PNMI staff person's hourly compensation amount.

(b) This subsection will apply to limit all forms of compensation reported on the funding application, including imputed compensation amounts per subsection 4.13(b).

**5 CLASSIFICATION OF COSTS AND ASSIGNMENT TO SERVICE CATEGORIES**

**5.1 General**

In the PNMI system of reimbursement, allowable costs are first classified and then assigned to a service category. Costs are classified into cost categories as set forth by the Director on the funding application.

**5.2 [Repealed]**

**5.3 Service and Administration Categories**

There are three service categories that are directly related to the provision of services to the residents and a fourth category which relates to the administration of the program. All allowable program costs shall be allocated to these four categories. To determine total allowable program costs, the administration category is re-allocated to the three service categories.

(a) Service Categories

(1) Treatment: Treatment services are those services whose goal is to achieve the maximum reduction of physical or mental disability and rehabilitation of a resident to his or her highest possible functional level. Treatment services directly involve individual care as prescribed in the plan of care for a particular resident, or support the program's plan of care for a particular resident.

(2) Education: Educational costs are those costs incurred providing academic instruction to the program residents as part of an educational curriculum delivered or supervised by certified teaching staff. Not all programs provide approved academic services, and therefore not all facilities will have educational costs.

(3) Room, Board and Supervision: These costs include all direct resident care associated with sheltering, feeding and supervising the residents. This category does not include costs associated with carrying out treatment plan of care objectives or education objectives.

(b) Program Administration: In addition to the service categories above, administrative expenses related to the operation of the program are recognized allowable costs. Program administration costs include direct program administrative costs and indirect administrative allocations.

## **6 REIMBURSEMENT STANDARDS**

### **6.1 Prospective Reimbursement System and the Per Diem Rate**

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

(b) Per diem rates shall be prospectively determined for the rate year based on the allowable operating costs of a facility in a base year.

(c) For each resident enrolled in a participating private nonmedical institution, a per diem rate will be paid, set according to these rules and specified in the provider contract.

(d) The per diem rate payment will be considered payment in full for all covered services for that day and shall be used by all PADs to reimburse for services provided during the contract period subject to the limitations in Section 10. Billing and payment procedures shall be determined by the PADs.

(e) No separate billing may be made by the program provider or any other provider for any type of service which has been included in the approved program costs. If a provider is unsure whether a type of service has been included in the approved program costs, it must refer the question to the Division which will issue a determination after consultation with the PADS.

### **6.2 Temporary Absences**

Reimbursement may be available for temporary absences from the facility of up to fifteen days per episode in accordance with provider contract provisions, subject to preapproval by the appropriate child placement agency.

**6.3 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 Section 9;

(2) in response to a decision by the Secretary pursuant to subsection 12.4 or to an order of a court of competent jurisdiction;

(3) for mechanical computation or typographical errors;

(4) as a result of revised findings resulting from the reopening of a settled funding application pursuant to subsection 3.4(b)(2);

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

(6) recovery of overpayments pursuant to subsection 10.1 as a result of a provider exceeding the contract maximum; or

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

**6.4 Interim Rates**

(a) The Division may set interim rates for any or all programs. 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.

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

**6.5 Base Year**

(a) A base year shall be a program's fiscal year.

(b) All costs shall be rebased on October 1, 2013. Subsequent rebasing shall occur every July 1 thereafter beginning with July 1, 2014.

(c) The determination of a base year shall be a notice of practices and procedures pursuant to subsection 1.8(d).

**6.6 Occupancy Level**

(a) Occupancy levels used in calculating the per diem rate will be determined by using guidelines prescribed by the Division in consultation with the PADs.

(b) The determination of occupancy levels shall be a notice of practices and procedures pursuant to subsection 1.8(d).

(c) Exceptions to the occupancy guidelines may be granted only in limited circumstances at the discretion of the Director, in consultation with the PADs.

**6.7 Cap on Increases from Prior Base Year to Current Base Year**

The Division shall cap the programs' increases by calculating a maximum increase from the prior base year to the current base year pursuant to this subsection.

(a) For programs with rates calculated pursuant to subsection 7.4, the Division shall calculate a cap for each program's per diem rate as follows:

(1) The Division will add back to the prior base year per diem rate any revenue offset amounts, also brought to a per diem rate basis, made for the recapture of net PNMI revenue in excess of five percent pursuant to subsection 7.6.

(2) The Division shall determine an occupancy adjusted per diem rate. This occupancy adjusted per diem rate will compensate for the increase in the per diem rate that occurs when a lower number of resident days is used in the rate calculation. In calculating the occupancy adjusted per diem rate, the Division will use the resident days from the prior base year rate calculations. The occupancy adjusted per diem rate will be calculated as follows:

(i) If the current base year resident days are equal to or greater than the prior base year resident days, the division shall multiply the prior year per diem rate as calculated pursuant to paragraph (a)(1), excluding rate adjustments, by 100%. The result will be the occupancy adjusted per diem rate.

(ii) If the current base year resident days have decreased from the prior base year resident days that were

used in the rate calculation, but are still above the program's minimum allowed occupancy established pursuant to subsection 6.6, the current base year actual days will be used to calculate the percentage decrease in days from the prior base year to the current base year. The Division shall multiply the prior base year per diem rate as calculated pursuant to paragraph (a)(1), excluding rate adjustments, by 100% plus the percentage decrease in resident days from the prior base year to the current base year. The result will be the occupancy adjusted per diem rate.

(iii) If the current base year resident days have decreased from the prior base year resident days that were used in the rate calculation, but are now below the program's minimum allowed occupancy established pursuant to subsection 6.6, the program's minimum allowed occupancy will be used to calculate the percentage decrease in days from the prior base year to the current base year. The Division shall multiply the prior base year per diem rate as calculated pursuant to paragraph (a)(1), excluding any rate adjustments, by 100% plus the percentage decrease in the resident days from the prior base year. The result will be the occupancy adjusted per diem rate.

(3) Allowed Percentage Increase to the Occupancy Adjusted Per Diem Rate

The table below shows the factor to be applied to the occupancy adjusted prior base year per diem rate to

**Private Non-Medical Institutions**

calculate the cap on the current year per diem rate in accordance with paragraph (a)(4). This factor is on a scale that relates to the magnitude of the programs' prior base year allowable costs before revenue offset.

Prior Base Year Allowable Costs Before Revenue Offset	Allowed Percentage Change for Cost Increases
Up to \$600,000	6.0%
\$600,001 - \$1,000,000	5.0%
\$1,000,001 - \$1,800,000	4.0%
\$1,800,001 - \$4,000,000	3.0%
Over \$4,000,000	2.0%

(4) The cap on the current year per diem rate, excluding rate adjustments, is the occupancy adjusted prior base year per diem rate calculated pursuant to paragraph (a)(2), multiplied by 100% plus the factor from the table in paragraph (a)(3). The result will be the maximum per diem rate the provider may receive for the current base year. Existing and new rate adjustments will be added to the capped per diem rate for the total allowed per diem rate.

(b) For crisis/stabilization programs with rates calculated pursuant to subsection 7.5, the Division shall cap cost increases from year to year as follows:

(1) The Division will add back to the prior base year allowable costs any revenue offset amounts made for the recapture of net PNMI revenue in excess of five percent pursuant to subsection 7.6. This will be the allowable costs for the year to year comparison.

(2) The prior base year allowable costs, calculated pursuant to paragraph (b)(1), multiplied by 100% plus the factor from the table below will be the cap on annual costs used for reimbursement for the current base year. Existing and new rate adjustments amounts will be added to this cap to determine the maximum allowed costs.

Prior Base Year Allowable Costs Before Revenue Offset	Allowed Percentage Change for Cost Increases
Up to \$600,000	6.0%
\$600,001 - \$1,000,000	5.0%
\$1,000,001 - \$1,800,000	4.0%
\$1,800,001 - \$4,000,000	3.0%
Over \$4,000,000	2.0%

(c) An exemption from the cap calculated pursuant to paragraphs (a) and (b), may be available at the discretion of the PADs in the following instances:

(1) for an existing program that is converted to a PNMI until the second full year that the program's base year actual annual costs from operating as a PNMI are used for rate setting.

(2) for a new PNMI start-up program, pursuant to subsection 4.20, until the second full base year where actual annual costs are used for rate setting.

## 7 CALCULATION OF COSTS, LIMITS AND RATES FOR PNMI FACILITIES

### 7.1 [Repealed]

### 7.2 Approved Program Costs

The calculation of the rates shall be based on total allowable base year costs determined by the Division pursuant to these rules.

### 7.3 [Repealed]

### 7.4 Calculation of Per Diem Rate

(a) Using each program's settled base year funding application, a per diem rate shall be calculated by dividing the total allowable base year costs by the total base year resident days, subject to minimum occupancy requirements.

(b) The Division shall limit the current rate period's per diem rate by the cap calculated pursuant to subsection 6.7.

(c) Existing and new rate adjustments will be added to the per diem rate calculated pursuant to this subsection for the total allowed per diem rate.

(d) The Division shall develop a per diem rate for each of the service categories as set out in subsection 5.3.

(e) During the State of Emergency declared by the Governor of the State of Vermont on March 16, 2020 all programs rates will be retroactively set in accordance with subsection 7.5 below. This subsection will remain in effect until 60 days after the State of Emergency terminates or until the PADs determine the methodology is no longer needed, whichever is sooner.

## 7.5 Calculation of Per Diem Rates for Crisis/Stabilization Programs

For programs categorized by the PADs as crisis/stabilization programs with typical lengths of stay from 0 – 10 days and for all other programs during the State of Emergency declared by the Governor of the State of Vermont on March 16, 2020 regarding the outbreak of COVID-19, rates are set retroactively as follows:

(a) Using each program's settled base year funding application, the monthly total allowable costs are calculated by dividing the total allowable costs by 12.

(b) Within five days of the end of each month, the program shall submit the prior month's census to the Division. The Division shall calculate the per diem rate by dividing the monthly allowable costs by the total number of resident days for the month just ended.

(c) The Division shall limit increases from year to year in total allowable base year costs of crisis/stabilization programs by the cap calculated pursuant to subsection 6.7(b).

(d) Existing and new rate adjustment amounts will be added to the current base year allowable costs for the total allowed program costs.

(e) Rate setting under this subsection for programs that are not classified as crisis/stabilization programs will end 60 days after the State of Emergency terminates or until the PADs determine the methodology is no longer needed, whichever is sooner. Thereafter, rates will be set in accordance with subsection 7.4 above.

**7.6 Recapture of Net PNMI Revenue in Excess of Five Percent**

The Division will review programs' audited financial statements and will recapture PNMI profit by applying the net revenue in excess of five percent against the current year's total allowable costs. The calculation of the recapture of net PNMI revenue in excess of five percent shall take into consideration the effect of the cap in subsection 6.7. Any amounts of revenue offset which are greater than the effect of the cap will be offset.

**8 ADJUSTMENTS TO RATES**

**8.1 Procedures and Requirements for Rate Adjustments**

Applications for rate adjustments pursuant to this section shall be made as follows.

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

(b) No adjustment shall be made which would result in payments exceeding any limits set out in these rules or in the provider contract.

(c) No application for a rate adjustment should be made if the change would be de minimis or immaterial. The Division shall establish and certify the materiality

guidelines for purposes of providers applying for rate adjustments.

**8.2 Approval of Application**

(a) The burden of proof is at all times on the provider to show that the conditions for which the adjustment has been requested are reasonable, necessary and related to resident care, and are the result of required program changes or true emergencies or circumstances that were not foreseeable at the time the current rate was set.

(b) Approval of any application for a rate adjustment under this section is at the sole discretion of the Director in consultation with designees representing the PADs. 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. Once the application filing is deemed completed, the Division will issue its findings within 30 days.

(c) The occupancy percentage used for new costs in a rate adjustment application will be the current occupancy, as determined by the Division and subject to minimum occupancy requirements, if the current occupancy is different than the base year occupancy percentage.

(d) In the event that a rate adjustment is approved, the new rate will be effective for service provided from the first day of the month in which the draft findings and order were issued or following the date

the assets are actually put into service or expenses incurred, whichever is later.

(e) Approved rate adjustments will not be subject to the cap limitation pursuant to subsection 6.7.

### **8.3 Limitations 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 provider exceed the rate of payment.

## **9 EXTRAORDINARY FINANCIAL RELIEF**

Extraordinary financial relief may be available, at the discretion of the PADS, for a provider that the Division determines to be experiencing demonstrable and temporary financial difficulties. This provision does not create any entitlement to a rate in excess of that which the provider would receive under the normal operation of these rules or to any other form of relief.

(a) Based on the individual circumstances of each case, the PADS may authorize extraordinary financial relief on such conditions they shall find appropriate based on any one or a combination of the following: exemption of a program from the minimum occupancy guidelines, retroactive implementation of a rate adjustment at an earlier point in the rate period, increase in approved program costs, or such other relief as the PADS may find appropriate.

(b) After the end of the contract period, the Division shall review rates set pursuant to this subsection to determine whether revenues during the contract period

exceeded the approved program costs. To the extent that revenues exceed the approved program costs for the contract period, the Division shall apply such excess against the program's costs for the current period pursuant to V.P.N.M.I.R. §7.6, except that no allowance shall be made for excess revenues of up to five percent, and all excess revenues shall be applied unless the Division determines that such application of excess revenues would create further financial difficulties.

(c) Procedure - An application for extraordinary financial relief shall be in writing and filed with the Division. It shall be supported by such documentation as the Division may require. 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 decision, the application shall be denied, unless additional proofs are submitted.

(d) Since relief under this subsection is purely discretionary, the PADS shall not be bound in considering any prior decision made on any previous application under this subsection and decisions under this subsection shall have no precedential value either for the applicant program or for any other program.

## **10 LIMITATIONS ON PAYMENTS**

### **10.1 Contract Maximum**

Notwithstanding any other provision of these rules to the contrary, no provider shall be paid for services performed during the contract period any more than the maximum per diem rate or the maximum total amount specified in the contract.

### **10.2 Upper Payment Limits**



## **Private Non-Medical Institutions**

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(a) Medicaid payments to a provider may not exceed the upper limits established by 42 C.F.R. §447.362.

(b) The PADs reserve the right to terminate any provider contract if it determines that payments under the contract will exceed the Medicaid upper limits.

### **10.3 Lower of Rate or Charges**

At no time shall the total per diem rate for all service categories exceed the provider's customary charges to the general public for the same services.

## **11 PAYMENT FOR INTERSTATE PLACEMENTS**

### **11.1 Out-of-State Services**

(a) No reimbursement for PNMI residential child care services shall be available unless prior authorization has been granted by a PAD.

(b) The rate for preauthorized out-of-state residential child care services shall be the rate paid by the PAD or its equivalent in the state in which the facility is located.

### **11.2 In-State Services for Out-of-State Authorities**

Reimbursement shall not be made by the state of Vermont or any of its subdivisions for PNMI residential child care services provided to children placed in Vermont residential treatment programs by out-of-state child placement authorities. Support, as well as maintenance, of the child is required of the sending state as mandated by the

Interstate Compact on the Placement of Children.

## **12 ADMINISTRATIVE REVIEW AND APPEALS**

### **12.1 Draft Findings and Decisions**

(a) Before issuing findings on any desk review or audit of a funding application, request for a rate adjustment, or other request excluding extraordinary financial relief, the Division shall serve a draft of such findings or decision on the affected provider.

(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.

### **12.2 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 12.1(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 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 action.

(c) A request for an informal conference must be pursued before a request for reconsideration can be filed pursuant to subsection 12.3.

(d) Should no timely request for an informal conference be filed within the time period specified in subsection 12.2(a), the Division's draft findings and/or decision are final and no longer subject to administrative review or judicial appeal.

### **12.3 Request for Reconsideration**

(a) A provider that is aggrieved by an official action issued pursuant to subsection 12.2(b) may file a request for reconsideration.

(b) 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. Should no timely request for an informal conference be filed within the time period specified in this paragraph, the official action issued pursuant to subsection 12.2(b) is final and no longer subject to administrative review or judicial appeal.

(c) The request for reconsideration shall include 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 Publication 15, or other au-

thority 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.

(d) 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.

(e) 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.

(f) 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. Representatives of the PADs may also appear and may present evidence. The Director, or her or his designee, may hold the record open to a date certain for the receipt of additional materials.

(g) The Director shall issue a final order on the request for reconsideration no later than 30 days after the record closes.

### **12.4 Request for Administrative Review**

(a) Within 30 days of the receipt of a final order of the Division, a provider that feels aggrieved by that order may file a request for administrative review by the Secretary of the Agency of

## **Private Non-Medical Institutions**

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Human Services or a person designated by the Secretary.

(b) Proceedings under this section shall be initiated by the filing of a written request for administrative review for which forms may be prescribed by the Director. The appeal shall be filed with the Director of the Division, who, within 10 days of the receipt of the request, shall forward to the Secretary a copy of the request and the materials that represent the documentary record of the Division's action.

(c) The Secretary or the designee shall review the record of the appeal and may review such additional materials as he or she shall deem appropriate, and may, if requested by the provider, convene a hearing on no less than 10 days written notice to the provider, the Division and the PADs. Within 60 days after the close of the record, the Secretary or the designee shall issue a final determination which shall be served on the parties.

### **12.5 General Provisions**

(a) The effective date of actions or orders issued pursuant to this section shall be the effective date as set out in the Division's draft findings or decision, unless that date is at issue in the appeal.

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

## **13 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.

**AICPA:** American Institute of Certified Public Accountants.

**Allocable Cost:** A cost which is incurred for a service that is designed to achieve two or more objectives, not all of which are covered by the Medicaid program.

**Allowable Costs or Expenses:** those direct and indirect costs or expenses incurred for the provision of direct resident services and equipment used in the provision of such services. Direct resident services refers to room, board, care, rehabilitation and treatment, and may include educational services provided by programs to their residents.

**AOE:** the Vermont Agency of Education.

**Approved Program Costs:** the total allowable costs of a program in a base year.

**Adjusted Allowable Costs:** the net allowable costs of a program after the recapture of net PNMI revenue in excess of five percent.

**Base Year:** a program's fiscal year for which the allowable costs are the basis for the prospective per diem rate.

**Certified Rate:** the rate certified by the Division of Rate Setting to the PADs.

**Centers for Medicare and Medicaid Services (CMS):** Agency within the U.S. Department of Health and Human Services

(HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.

**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.

**Contract:** a provider contract is a standard form contract or standard form grant between a PAD and a Private Nonmedical Institution, which describes the services to be provided and includes the per diem rate. A provider contract pursuant to these rules does not include a contract with a residential treatment program that provides services based on individualized budgets for each child or that includes a master grant case rate or per member per month funding mechanism that is applicable for a broad array of services beyond just residential treatment services.

**Contract Period:** The twelve month period covered by the provider contract.

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

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

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

**DMH:** Department of Mental Health.

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

**Facility:** a residential treatment program, licensed as such by the Department for Children and Families' Residential Licensing and Special Investigations Unit, and enrolled in the Vermont Medicaid Program as a Private Nonmedical Institution for Child Care Services.

**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:** an action of the Division that is no longer subject to change by the Division and for which no further review or appeal is available from the Division.

**Fringe Benefits:** shall include payroll taxes, workers compensation, pension, group health, dental and life insurances, profit sharing, cafeteria plans and flexible spending plans.

**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.

**Funding Application:** A cost report prepared by the provider in accordance with instructions and on forms prescribed by the Division.

## Private Non-Medical Institutions

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**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 market basket, home health agency market basket and regional forecasts of consumer price indexes.

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

**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.

**Interim Rate:** a prospective rate paid to a program on a temporary basis.

**Occupancy Level:** the number of paid days, including temporary absence days, as a percentage of the total permitted number of total permitted resident capacity.

**Occupancy Adjusted Per Diem:** the prior year per diem, excluding any rate adjustments, adjusted for a decline in resident days from the prior base year to the current base year, subject to minimum occupancy limits.

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

**Placement Authorizing Department (PAD):** the State governmental entity responsible (solely or in conjunction with another State entity) for authorizing the placement of a child in a residential treatment program. PADs include but are not limited to the Department for Children and Families, the Department of Mental Health, the Department of Disabilities, Aging and Independent Living, Division of Alcohol and Drug Abuse Programs or the Agency of Education in coordination with the Local Education Agency.

**Private Nonmedical Institution (PNMI):** an organization or program that is not, as a matter of regular business, a health insuring organization, hospital, nursing home, or a community health care center, that provides medical care to its residents. A Private Nonmedical Institution for Residential Child Care Services must be licensed by the Department for Children and Families' Residential Licensing and Special Investigations Unit and have a Medicaid Provider Agreement in effect with the Department of Vermont Health Access.

**Program:** a residential treatment program, licensed as such by the Department for Children and Families' Residential Licensing and Special Investigations Unit, and enrolled in the Vermont Medicaid Program as a Private Nonmedical Institution for Child Care Services.

**Provider Agreement:** a provider agreement is an agreement to provide, and receive payment for, Medicaid services according to the terms and conditions established by the PADs. A provider agreement must be in effect and on file with the Department of Vermont Health Access for an organization to be considered authorized to bill and receive payments from the Medicaid program.

**Provider Reimbursement Manual, CMS Publication 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:** an individual who is receiving services in a Private Nonmedical Institution for Residential Child Care Facility.

**Resident Day:** the care of one resident for one day of services. The day of admission is counted as one day of care, but the day of discharge is not. A resident day also includes a temporary absence day.

**Residential Treatment Program:** a private or public agency or facility that is licensed by the Department for Children and Families' Residential Licensing and Special Investigations Unit under the "Licensing Regulations for Residential Treatment Programs".

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

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

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

#### 14 TRANSITIONAL PROVISIONS

(a) The Division shall add \$500 to the state fiscal year 2014 total rate year allowable costs for each program so that programs may begin to request that their the independent public accountants prepare the PNMI sub-schedule as part of each program's next annual audit pursuant to subsection 1.7(d) and 3.2(d). If the costs for these sub-schedules are not in the programs' state fiscal rate year 2015 costs, the Division will also add \$500 to the base total allowable costs so that programs may have this PNMI sub-schedule prepared as part of the annual audit.

(b) Notwithstanding any other provisions of

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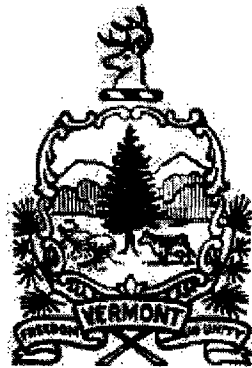
these rules, the amendments to these rules effective February 24, 2014 shall be applied to payments for services rendered on or after October 1, 2013. The base year for rates effective October 1, 2013 shall be providers' fiscal year 2012 costs.

(c) Programs shall be exempt from the penalty provisions of subsection 3.3(d) in the state fiscal year 2014 rate period.

(d) The first year that the Division shall apply the cap pursuant to subsection 6.7. is the rate year that uses base year 2014 costs.

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**STATE OF VERMONT  
AGENCY OF HUMAN SERVICES  
DIVISION OF RATE SETTING**



**METHODS, STANDARDS AND PRINCIPLES FOR  
ESTABLISHING PAYMENT RATES FOR  
PRIVATE NONMEDICAL INSTITUTIONS  
PROVIDING RESIDENTIAL CHILD CARE SERVICES**

**APRIL 9, 2020**



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## 1 GENERAL PROVISIONS

### 1.1 Scope and Purpose

These rules apply to all private nonmedical institutions that are participating in the Vermont Medicaid program, providing services in licensed residential treatment programs and that have a contract with at least one of the placement authorizing departments (PAD) as defined in Section 13 of these rules. The purpose of these regulations is to establish the methods, standards and principles used to determine and calculate payment rates for these services consistent with efficiency, economy and quality of care, in compliance with Title XIX of the Social Security Act, and to ensure that no Medicaid reimbursement is made for non-covered services. These rules identify those costs that are allowable as the basis for setting rates.

### 1.2 Authority

These rules are promulgated pursuant to 33 V.S.A. §1901(a) to meet the requirements of 33 V.S.A. Chapter 3, 42 U.S.C. §1396a(a)(30), and 42 C.F.R. Part 434, Subpart B (relating to private nonmedical institutions.)

### 1.3 General Description of the Rate Setting System

Payment rates are established prospectively for each program based on historic allowable costs of the program. A per diem rate is established for each major category of service provided by these facilities: medical treatment; room, board and supervision; and education. The approved rate is based on a funding application and financial state-

ments submitted to the Division by the provider.

### 1.4 Requirements for Participation in Medicaid Program

To be eligible to participate in the Medicaid program and receive Medicaid reimbursement, a program must be licensed by the Department for Children and Families' Residential Licensing and Special Investigations Unit, have an approved Medicaid provider agreement with Department of Vermont Health Access, and have an approved contract with at least one of the placement authorizing departments (PAD) as defined in Section 13 of these rules.

### 1.5 Prior Authorization of Placement

Prior authorization by a PAD is required for all admissions to residential treatment programs for which payment is anticipated from the State or a political subdivision thereof.

### 1.6 Responsibilities of Owners

The owner of a residential treatment program shall prudently manage and operate a program of adequate quality to meet its residents' needs and comply with the rules and regulations or other requirements and standards of the Agency of Human Services and the Agency of Education, including the Department for Children and Families' Licensing Regulations for Residential Treatment Programs. Neither the issuance of a per diem rate, nor final orders made by the Director or a duly authorized representative of a PAD shall in any way relieve the owner of such a program from full responsibility for such compliance.

### **1.7 Duties of the Owner**

The owner of a residential treatment program participating in the Medicaid program, or a duly authorized representative shall:

- (a) Comply with the provisions of subsections 1.4, 1.5 and 1.6 setting forth the requirements for participation in the Medicaid program.
- (b) Submit master file documents, funding applications and supporting documentation in accordance with the provisions of subsections 3.1 and 3.2 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 by an independent public accountant in conformance with Generally Accepted Auditing Standards (GAAS), including a sub-schedule, when applicable, showing total PNMI revenues and costs, including allocated costs, and showing PNMI net program revenues.
- (e) Report to the Division within 30 days when there has been a change of ownership or ownership structure of the program.
- (f) Assure that the construction of buildings and the maintenance and operation of premises and programs comply with all applicable health and safety standards.

### **1.8 Powers and Duties of the Division of Rate Setting and the Director**

- (a) The Division shall establish and certify to the appropriate PADs per diem rates for payment to providers of residential child care services on behalf of residents eligible for assistance under the Social Security Act.
- (b) The Division may require any residential treatment program 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 rate setting function.
- (c) The Division may examine books and accounts of any program and related parties or organizations.
- (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 the general representative of each residential treatment program 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) The Division shall prescribe procedures and forms to be used in the completion of time studies.

(h) The Division, in consultation with the PADs, shall establish and certify the occupancy standards to be used in the rate setting process.

(i) 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 requirements of these rules shall be construed as a waiver of such requirements in the future. The obligations of the provider with respect to performance shall continue, and the Division shall not be estopped from requiring such future performance.

(j) Neither the Division nor the PADs shall be bound in determining the allowability of reported costs, in ruling on applications for rate adjustments, or in making any other decision relating to the establishment of rates, by any prior decision. Such decisions shall have no precedential value. Principles and decisions of general applicability shall be issued as a Division practice or procedure, pursuant to Section 1.8(d).

(k) Notwithstanding any other provisions of these rules, the Division may, at the discretion of the Director, establish and certify per diem rates pursuant to these rules for licensed Vermont residential treatment programs for the use of other states placing children in the program when the program is not currently contracting with a Vermont PAD to place children.

**1.9 Powers and Duties of the Department for Children and Families, Department of Mental Health, Department of Disabilities, Aging and Independent Living, Department of Health's Division of Alcohol and Drug Abuse Programs and Agency of Education and other PADs relating to Rate Setting**

(a) The PADs shall establish and enforce billing and payment procedures.

(b) The PADs reserve the right to review, modify, accept or reject any adjustment requests made in accordance with Sections 8 and 9 of these rules.

(c) The Department for Children and Families is responsible for licensing standards and enforcement. The PADs are responsible for program standards, placement procedures, and contract enforcement.

**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 ad-

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.

(d) Filing shall be deemed to have occurred when a document is received and date-stamped as received at the office of the Division of Rate Setting 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 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 of Rate Setting**

(a) A provider 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 executive officer of the PNMI, 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**

These rules are effective from July 25, 1995 (as amended August 1, 1999, August 1, 2003, August 5, 2008, February 24, 2014 and September 8, 2015).

**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 from 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 standards governing the performance of their employees engaged in purchasing goods and services. Such standards shall provide, to the maximum extent practical, open and free competition among vendors.

(b) Any purchase that fails to satisfy the prudent buyer principle in CMS

Publication 15 §2103 is subject to a disallowance.

**2.3 Cost Allocations**

(a) Certain costs which cannot correctly be identified as entirely belonging to the PNMI or to a single service category within the PNMI must be allocated to each program and service category in a manner that reflects the appropriate share of costs for each eligible category.

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

(1) Salaries/wages - Time reporting identifying and dividing time between that spent working for the PNMI and time working in other programs operated by the central office.

(2) Employee Benefits - shall be allocated to reflect the actual allowable expenses for the employees identified as directly working in each program(s) (worksheets are required to support the actual expense allocation method) or the portion of total agency employee benefit expenses that equals the ratio of gross salary and wages for the particular program(s) to the total gross salary and wages for the agency.

(3) Facility costs and costs of operation and maintenance - may be allocated on the basis of the square footage dedicated to the PNMI program and within the PNMI program. Facilities must provide a floor plan and square footage calculation supporting the allocation. If allocation by square footage is not feasible, then an alternative method shall be established by agreement between the provider and the Division.



(4) Food and Laundry - For the PNMI program, allocated on the ratio of PNMI residents to total residents.

(c) Only such costs as are determined by the Division to be reasonable pursuant to these rules shall be allocated to the PNMI program.

#### **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, medical, and statistical records, to substantiate the data reported on the funding application and on prior year's funding applications and shall, upon request, make these records available to authorized representatives of the Vermont Agency of Human Services and the United States Department of Health and Human Services.

(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 charge 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 retain all such records for at least four years after final payment is received and all pending matters are closed.

(d) The Division shall keep all funding applications, supporting documentation submitted by the provider, correspondence, workpapers and other analyses supporting summaries of findings or other decisions for at least four years after final payment is made and all pending matters are closed.

(e) An additional retention period is required if an audit, litigation, or other legal action involving the records is started before or during the original four-year period. The provider and Division shall retain all records which are in any way related to such action until the matter has terminated and any applicable appeal period has passed.

(f) Pursuant to 1 V.S.A. §317(b), financial records filed with the Division are public records, except for records containing material which would reveal personal information about a resident.

### 3 FINANCIAL REPORTING

#### 3.1 Master File

Providers shall submit the following documents for the purpose of establishing a Master file for each facility in the Vermont Medicaid program:

- (a) Description of current ownership structure, including copies of the articles of incorporation and bylaws,
- (b) description of plant layout,
- (c) current list of the board of directors,
- (d) personnel policies, and
- (e) such other documents or information as the Director may require.

#### 3.2 Funding Application and Financial Reporting

- (a) Funding applications and supporting documentation for services provided by these facilities shall be reported on forms prescribed by the Director pursuant to Section 1.8.
- (b) The funding application must include the certification page signed by the owner or the program's representative, if authorized in writing by the owner.
- (c) The original signed funding application must be submitted to the Division. The original document must bear an original signature. The funding application must also be submitted to the Division in electronic format as prescribed by the Director.

(d) A provider must submit audited financial statements with the funding application, including a sub-schedule, when applicable, showing total PNMI revenues and costs, including allocated costs, and showing PNMI net program revenues.

(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, including, but not limited to:

- (1) current program narrative including description of treatment milieu,
- (2) depreciation schedule,
- (3) post-audit adjusted trial balance,
- (4) list of all related parties to the program and disclosure of transactions with related parties,
- (5) chart of accounts with account descriptions
- (6) schedules for amortization of long-term debt and depreciation of fixed assets,
- (7) list of vehicles used by the program along with a vehicle mileage summary, including beginning and ending odometer reading for the year and percentage of personal use,
- (8) list of buildings used by the program, including a description of the purpose of each building and information about whether each building is owned or leased,

(9) schedule of employee benefits, which includes the total cost of each benefit compared to total salaries,

(10) copies of all contracts with consultants and contractors for services provided to the PNMI program equal to and greater than \$5,000 and

(11) any updated documents or changes to documents submitted as part of the program's master file pursuant to section 3.1.

(f) If before the draft findings are issued, the provider has been specifically requested to provide certain information or materials pursuant to paragraph (e), and has failed to do so, such information or materials will not be admissible in any subsequent appeal taken pursuant to Section 12.

### 3.3 Adequacy and Timeliness of Filing

(a) The funding application and requested supporting documentation must be filed with the Division on a schedule to be prescribed by the Director.

(b) The Division may reject any funding application which does not meet these rules. In such a case, the funding application shall be deemed not filed, until refiled and in compliance.

(c) Extensions for filing of the funding application and requested supporting documentation beyond the prescribed deadline must be requested as follows:

(1) All requests for extension of time to file a funding application and supporting documentation must be in writing, on a form prescribed by the

Director, and must be received by the Division of Rate Setting prior to the filing deadline. The provider must clearly explain the reason for the request and specify the date on which the Division will receive the information.

(2) 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 an accountant or funding application preparer engaged in other work.

(d) When rate setting is delayed because the funding application and supporting documentation are incomplete or untimely, or requested information is not provided in a timely manner, the rate for the previous rate year will remain in effect. The new rates will take effect from the first day of the month following the Division's final order when such order results in an increase in the per diem rate. Final orders resulting in a decrease in the per diem rate, will take effect from the first day of the rate period.

### 3.4 Review of Funding Applications by Division

(a) Desk Review

(1) The Division shall perform a desk review on each funding application submitted.

(2) The desk review is an analysis of the provider's funding application 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 setting the rate without an on-site audit or determining the extent to which an on-site audit verification is required.

(3) Desk reviews shall be completed within nine months after receipt of an acceptable funding application filing, except in unusual situations, including but not limited to, delays in obtaining necessary information from a provider. Difficulties in obtaining necessary information in a timely fashion may result in delays in completion of the reviews and in the setting of rates.

(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 desk review.

**(b) On-site Audit**

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

(2) The Division may also reopen and audit prior years' settled funding applications if there is evidence and/or complaints of financial irregularities at the program.

(3) 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 Section 12.

**3.5 Settlement of Funding Applications**

A funding application 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 12.3 of these rules.

**4 DETERMINATION OF ALLOWABLE COSTS**

**4.1 Incorporation of Provider Reimbursement Manual**

In determining the allowability or reasonableness of cost 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 Publication 15, formerly known as HCFA-15), which is hereby incorporated by reference. If neither these regulations nor CMS Publication 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

(a) To be allowable, a cost must satisfy criteria, including but not limited to the following:

(1) The cost is ordinary, reasonable, necessary and related to the direct care of residents.

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

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

(b) Allowable costs include those costs incurred for the provision of resident services and equipment used in the provision of such services, including

(1) direct qualified staff salaries and benefits,

(2) other direct program costs,

(3) direct program administrative costs and

(4) indirect allocated administrative (central office) costs.

(c) An unallowable cost is one which is not incurred for resident services, related administrative services, common or joint program objectives, or is determined to be unreasonable, unnecessary or duplicative.

## 4.3 Preapproval by PADs

Preapproval is encouraged for providers anticipating a significant increase in program expenses. Providers should obtain pre-approval from the Division, in

consultation with the PADs, before making commitments to any significant increase in expenditures in the current approved program costs or future allowable costs, since such increase may affect the suitability of the program and/or the ability of the PADs to continue to purchase the program services. Preapproved increases will not be subject to the cap limitation pursuant to subsections 7.4(b) and 7.5(c).

## 4.4 Non-Recurring Costs

Any reasonable and resident-related, non-capital cost that would increase the approved costs by two percent and is not expected to be a recurring cost in the ordinary operation of the facility, may be designated a "Non-Recurring Cost". A non-recurring cost shall be capitalized and amortized for a period of three years.

## 4.5 Property and Related Costs

Property and related costs include:

(a) depreciation on buildings and fixed equipment, motor vehicle, land improvements and amortization of leasehold improvements and capital leases.

(b) interest on capital indebtedness,

(c) real estate leases and rents,

(d) real estate/property taxes, or payments in lieu of property taxes, provided that they are legal obligations of the provider and do not exceed the amount of property taxes that would have been payable if the property were subject to property taxation.

(e) equipment rental,

(f) fire and casualty insurance,

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(g) amortization of mortgage acquisition costs and non-recurring costs, and

(h) repairs and maintenance.

### 4.6 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 program.

(2) Interest expense shall be reduced by realized investment income, with the exception of investment income on funded depreciation, pursuant to subsection 4.9.

(c) The Provider must have a legal obligation to pay the interest.

(d) "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 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:

(i) 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.

(ii) The costs are no higher than the rate charged by commercial lending institutions at the inception of the loan.

(e) Other costs may be included in loans where the interest is recognized by the Division. These costs include points and costs for legal and accounting fees, and discounts on debentures and letters of credit.

(f) In refinancing of indebtedness the provider must demonstrate that the costs of refinancing will be less than the allowable costs of the current financing. Costs of refinancing may include accounting fees, legal fees and debt acquisition costs related to the refinancing. The 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.

(g) Interest is not allowable with respect to any capital expenditures in property, plant or equipment related to resident care which requires preapproval pursuant to subsection 4.3, if the necessary approval has not been granted.

### 4.7 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 the cost or fair market value. Cost includes:

(1) purchase price,

(2) sales tax, and

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

(c) 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 above.

(d) 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 4.8.

#### **4.8 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 estimated useful life of an asset shall be determined 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.

#### **4.9 Funding of Depreciation**

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.

(a) As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense or as applied revenue if it meets the relevant requirements of CMS Publication 15.

(b) The provider must maintain appropriate documentation to support the funded depreciation account and interest earned to be eligible for this provision.

#### **4.10 Leasing Arrangements for Property, Plant and Equipment**

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

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

#### **4.11 Legal and Litigation Costs**

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

(b) Litigation costs related to criminal or professional practice matters are not allowable.

(c) 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 by the ratio of total dollars at issue in the case to the total dollars awarded to the provider, subject to the non-recurring costs provision, Subsection 4.4.

#### **4.12 Compensation of Owners, Operators, or their Relatives**

(a) Facilities that have a full-time (40 hours per week minimum) executive director and/or assistant director, 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 be limited to the following:

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

(2) The unduplicated functions actually performed.

(3) The hours actually worked and the number of employees supervised.

#### **4.13 Management Fees and Central Office Costs**

(a) Management fees, central office costs and other costs incurred by a program for similar services provided by other entities shall be included in the general and administrative cost classification. These costs are subject to the provisions for allowable costs, allocation of costs and related party transactions contained in these rules and may include property and related costs incurred for the management company. These costs are allowable only to the extent that such costs would be allowable if the PNMI facility provided the services for itself.

(b) Management fees will not be allowed for any individual owner or employee of a program or for any company owned or partially owned by any individual owner or employee of a program. However, if any individual owner or employee of a program receives management fees in lieu of salary or other compensation, the Division will apply the provisions of subsection 4.21 to impute a reasonable amount of compensation that may be allowed for PNMI reimbursement for the individual owner or employee. No consulting costs or any other form of compensation shall be allowed in addition to the imputed allowable salary amount.



#### **4.14 Advertising and Public Relations**

The following costs are not allowable:

(a) Advertising costs, other than those advertising expenses which are reasonable and necessary to recruit necessary qualified employees.

(b) Costs incurred for services, activities and events that are determined by the Division to be for public relations or fund raising purposes.

#### **4.15 Bad Debts, Charity, and Courtesy Allowances**

Bad debts, charity and courtesy allowances are not allowable costs.

#### **4.16 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 are the actual cost to the related party without any markup or any additional negotiated fees. The Division may require 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, including the related party audited financial statements.

#### **4.17 Applied Revenues**

Where a program or central office of the program reports revenues other than those received from per diem rates, these revenues shall be applied to reduce the allowable direct program costs or central

office allocation according to the following provisions.

(a) Investment Income - With the exception of income on funded depreciation allowed pursuant to subsection 4.9, and to the extent that interest expense is allowable, interest or investment income earned by the PNMI programs or central office will be applied against the program or central office costs when calculating the total allowable program costs.

(b) Restricted Contributions and Grant Income - Contributions which are grant income or restricted by the original donor will be applied against the PNMI direct program cost or central office allocation to the extent that the costs for that program or central office projects costs are payable from that revenue source. Restricted revenues generated through fund raising campaigns or events will be reduced by the costs incurred in raising these funds (including such otherwise unallowable expenses as advertising and public relations) before being applied against reported costs.

(c) Unrestricted Contributions - In general, contributions and donations which are not restricted by the donor will not be applied against the total allowable program costs.

#### **4.18 Travel/Entertainment Costs**

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

**4.19 Transportation Costs**

Costs of transportation incurred, other than ambulance services covered pursuant to the Vermont Medicaid Covered Services Rules, that are necessary and reasonable for the care of residents are allowable. Such costs shall include depreciation of 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. Providers shall keep vehicle mileage logs and other similar records to track program costs for transportation.

**4.20 Costs for New Programs and Start-Up Costs**

(a) Reimbursement for new programs may be based on budget cost reports submitted to the Division. The Division may periodically review and revise the budgeted start-up costs and rate for a program based on the actual operating costs and occupancy of the program.

(b) The PADs may authorize reimbursement for pre-opening start-up cost for new programs. Application for approval of such reimbursement should be made before the expense is incurred. Eligible costs may include, but are not limited to capital expenditures, supplies, staffing and training costs. Reimbursement may be made by lump-sum payments or by the addition of the start-up costs to the program's approved budget for its first year of operation.

**4.21 Compensation Limitations**

(a) Allowable compensation for any reported salary amounts on the funding application, including indirect or allocated salary amounts, shall be limited to a factor of seven times the lowest paid direct care non-allocated PNMI staff person's hourly compensation amount.

(b) This subsection will apply to limit all forms of compensation reported on the funding application, including imputed compensation amounts per subsection 4.13(b).

**5 CLASSIFICATION OF COSTS AND ASSIGNMENT TO SERVICE CATEGORIES**

**5.1 General**

In the PNMI system of reimbursement, allowable costs are first classified and then assigned to a service category. Costs are classified into cost categories as set forth by the Director on the funding application.

**5.2 [Repealed]**

**5.3 Service and Administration Categories**

There are three service categories that are directly related to the provision of services to the residents and a fourth category which relates to the administration of the program. All allowable program costs shall be allocated to these four categories. To determine total allowable program costs, the administration category is re-allocated to the three service categories.

(a) Service Categories

(1) Treatment: Treatment services are those services whose goal is to achieve the maximum reduction of physical or mental disability and rehabilitation of a resident to his or her highest possible functional level. Treatment services directly involve individual care as prescribed in the plan of care for a particular resident, or support the program's plan of care for a particular resident.

(2) Education: Educational costs are those costs incurred providing academic instruction to the program residents as part of an educational curriculum delivered or supervised by certified teaching staff. Not all programs provide approved academic services, and therefore not all facilities will have educational costs.

(3) Room, Board and Supervision: These costs include all direct resident care associated with sheltering, feeding and supervising the residents. This category does not include costs associated with carrying out treatment plan of care objectives or education objectives.

(b) Program Administration: In addition to the service categories above, administrative expenses related to the operation of the program are recognized allowable costs. Program administration costs include direct program administrative costs and indirect administrative allocations.

## **6 REIMBURSEMENT STANDARDS**

### **6.1 Prospective Reimbursement System and the Per Diem Rate**

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

(b) Per diem rates shall be prospectively determined for the rate year based on the allowable operating costs of a facility in a base year.

(c) For each resident enrolled in a participating private nonmedical institution, a per diem rate will be paid, set according to these rules and specified in the provider contract.

(d) The per diem rate payment will be considered payment in full for all covered services for that day and shall be used by all PADs to reimburse for services provided during the contract period subject to the limitations in Section 10. Billing and payment procedures shall be determined by the PADs.

(e) No separate billing may be made by the program provider or any other provider for any type of service which has been included in the approved program costs. If a provider is unsure whether a type of service has been included in the approved program costs, it must refer the question to the Division which will issue a determination after consultation with the PADS.

### **6.2 Temporary Absences**

Reimbursement may be available for temporary absences from the facility of up to fifteen days per episode in accordance with provider contract provisions, subject to preapproval by the appropriate child placement agency.

**6.3 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 Section 9;

(2) in response to a decision by the Secretary pursuant to subsection 12.4 or to an order of a court of competent jurisdiction;

(3) for mechanical computation or typographical errors;

(4) as a result of revised findings resulting from the reopening of a settled funding application pursuant to subsection 3.4(b)(2);

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

(6) recovery of overpayments pursuant to subsection 10.1 as a result of a provider exceeding the contract maximum; or

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

**6.4 Interim Rates**

(a) The Division may set interim rates for any or all programs. 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.

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

**6.5 Base Year**

(a) A base year shall be a program's fiscal year.

(b) All costs shall be rebased on October 1, 2013. Subsequent rebasing shall occur every July 1 thereafter beginning with July 1, 2014.

(c) The determination of a base year shall be a notice of practices and procedures pursuant to subsection 1.8(d).

**6.6 Occupancy Level**

(a) Occupancy levels used in calculating the per diem rate will be determined by using guidelines prescribed by the Division in consultation with the PADs.

(b) The determination of occupancy levels shall be a notice of practices and procedures pursuant to subsection 1.8(d).

(c) Exceptions to the occupancy guidelines may be granted only in limited circumstances at the discretion of the Director, in consultation with the PADs.

**6.7 Cap on Increases from Prior Base Year to Current Base Year**

The Division shall cap the programs' increases by calculating a maximum increase from the prior base year to the current base year pursuant to this subsection.

(a) For programs with rates calculated pursuant to subsection 7.4, the Division shall calculate a cap for each program's per diem rate as follows:

(1) The Division will add back to the prior base year per diem rate any revenue offset amounts, also brought to a per diem rate basis, made for the recapture of net PNMI revenue in excess of five percent pursuant to subsection 7.6.

(2) The Division shall determine an occupancy adjusted per diem rate. This occupancy adjusted per diem rate will compensate for the increase in the per diem rate that occurs when a lower number of resident days is used in the rate calculation. In calculating the occupancy adjusted per diem rate, the Division will use the resident days from the prior base year rate calculations. The occupancy adjusted per diem rate will be calculated as follows:

(i) If the current base year resident days are equal to or greater than the prior base year resident days, the division shall multiply the prior year per diem rate as calculated pursuant to paragraph (a)(1), excluding rate adjustments, by 100%. The result will be the occupancy adjusted per diem rate.

(ii) If the current base year resident days have decreased from the prior base year resident days that were

used in the rate calculation, but are still above the program's minimum allowed occupancy established pursuant to subsection 6.6, the current base year actual days will be used to calculate the percentage decrease in days from the prior base year to the current base year. The Division shall multiply the prior base year per diem rate as calculated pursuant to paragraph (a)(1), excluding rate adjustments, by 100% plus the percentage decrease in resident days from the prior base year to the current base year. The result will be the occupancy adjusted per diem rate.

(iii) If the current base year resident days have decreased from the prior base year resident days that were used in the rate calculation, but are now below the program's minimum allowed occupancy established pursuant to subsection 6.6, the program's minimum allowed occupancy will be used to calculate the percentage decrease in days from the prior base year to the current base year. The Division shall multiply the prior base year per diem rate as calculated pursuant to paragraph (a)(1), excluding any rate adjustments, by 100% plus the percentage decrease in the resident days from the prior base year. The result will be the occupancy adjusted per diem rate.

(3) Allowed Percentage Increase to the Occupancy Adjusted Per Diem Rate

The table below shows the factor to be applied to the occupancy adjusted prior base year per diem rate to

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calculate the cap on the current year per diem rate in accordance with paragraph (a)(4). This factor is on a scale that relates to the magnitude of the programs' prior base year allowable costs before revenue offset.

Prior Base Year Allowable Costs Before Revenue Offset	Allowed Percentage Change for Cost Increases
Up to \$600,000	6.0%
\$600,001 - \$1,000,000	5.0%
\$1,000,001 - \$1,800,000	4.0%
\$1,800,001 - \$4,000,000	3.0%
Over \$4,000,000	2.0%

(4) The cap on the current year per diem rate, excluding rate adjustments, is the occupancy adjusted prior base year per diem rate calculated pursuant to paragraph (a)(2), multiplied by 100% plus the factor from the table in paragraph (a)(3). The result will be the maximum per diem rate the provider may receive for the current base year. Existing and new rate adjustments will be added to the capped per diem rate for the total allowed per diem rate.

(b) For crisis/stabilization programs with rates calculated pursuant to subsection 7.5, the Division shall cap cost increases from year to year as follows:

(1) The Division will add back to the prior base year allowable costs any revenue offset amounts made for the recapture of net PNMI revenue in excess of five percent pursuant to subsection 7.6. This will be the allowable costs for the year to year comparison.

(2) The prior base year allowable costs, calculated pursuant to paragraph (b)(1), multiplied by 100% plus the factor from the table below will be the cap on annual costs used for reimbursement for the current base year. Existing and new rate adjustments amounts will be added to this cap to determine the maximum allowed costs.

Prior Base Year Allowable Costs Before Revenue Offset	Allowed Percentage Change for Cost Increases
Up to \$600,000	6.0%
\$600,001 - \$1,000,000	5.0%
\$1,000,001 - \$1,800,000	4.0%
\$1,800,001 - \$4,000,000	3.0%
Over \$4,000,000	2.0%

(c) An exemption from the cap calculated pursuant to paragraphs (a) and (b), may be available at the discretion of the PADs in the following instances:

(1) for an existing program that is converted to a PNMI until the second full year that the program's base year actual annual costs from operating as a PNMI are used for rate setting.

(2) for a new PNMI start-up program, pursuant to subsection 4.20, until the second full base year where actual annual costs are used for rate setting.

## **7 CALCULATION OF COSTS, LIMITS AND RATES FOR PNMI FACILITIES**

### **7.1 [Repealed]**

### **7.2 Approved Program Costs**

The calculation of the rates shall be based on total allowable base year costs determined by the Division pursuant to these rules.

### **7.3 [Repealed]**

### **7.4 Calculation of Per Diem Rate**

(a) Using each program's settled base year funding application, a per diem rate shall be calculated by dividing the total allowable base year costs by the total base year resident days, subject to minimum occupancy requirements.

(b) The Division shall limit the current rate period's per diem rate by the cap calculated pursuant to subsection 6.7.

(c) Existing and new rate adjustments will be added to the per diem rate calculated pursuant to this subsection for the total allowed per diem rate.

(d) The Division shall develop a per diem rate for each of the service categories as set out in subsection 5.3.

(e) During the State of Emergency declared by the Governor of the State of Vermont on March 16, 2020 all programs rates will be retroactively set in accordance with subsection 7.5 below. This subsection will remain in effect until 60 days after the State of Emergency terminates or until the PADs determine the methodology is no longer needed, whichever is sooner.

## **7.5 Calculation of Per Diem Rates for Crisis/Stabilization Programs**

For programs categorized by the PADs as crisis/stabilization programs with typical lengths of stay from 0 – 10 days and for all other programs during the State of Emergency declared by the Governor of the State of Vermont on March 16, 2020 regarding the outbreak of COVID-19, rates are set retroactively as follows:

(a) Using each program's settled base year funding application, the monthly total allowable costs are calculated by dividing the total allowable costs by 12.

(b) Within five days of the end of each month, the program shall submit the prior month's census to the Division. The Division shall calculate the per diem rate by dividing the monthly allowable costs by the total number of resident days for the month just ended.

(c) The Division shall limit increases from year to year in total allowable base year costs of crisis/stabilization programs by the cap calculated pursuant to subsection 6.7(b).

(d) Existing and new rate adjustment amounts will be added to the current base year allowable costs for the total allowed program costs.

(e) Rate setting under this subsection for programs that are not classified as crisis/stabilization programs will end 60 days after the State of Emergency terminates or until the PADs determine the methodology is no longer needed, whichever is sooner. Thereafter, rates will be set in accordance with subsection 7.4 above.

**7.6 Recapture of Net PNMI Revenue in Excess of Five Percent**

The Division will review programs' audited financial statements and will recapture PNMI profit by applying the net revenue in excess of five percent against the current year's total allowable costs. The calculation of the recapture of net PNMI revenue in excess of five percent shall take into consideration the effect of the cap in subsection 6.7. Any amounts of revenue offset which are greater than the effect of the cap will be offset.

**8 ADJUSTMENTS TO RATES**

**8.1 Procedures and Requirements for Rate Adjustments**

Applications for rate adjustments pursuant to this section shall be made as follows.

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

(b) No adjustment shall be made which would result in payments exceeding any limits set out in these rules or in the provider contract.

(c) No application for a rate adjustment should be made if the change would be de minimis or immaterial. The Division shall establish and certify the materiality

guidelines for purposes of providers applying for rate adjustments.

**8.2 Approval of Application**

(a) The burden of proof is at all times on the provider to show that the conditions for which the adjustment has been requested are reasonable, necessary and related to resident care, and are the result of required program changes or true emergencies or circumstances that were not foreseeable at the time the current rate was set.

(b) Approval of any application for a rate adjustment under this section is at the sole discretion of the Director in consultation with designees representing the PADs. 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. Once the application filing is deemed completed, the Division will issue its findings within 30 days.

(c) The occupancy percentage used for new costs in a rate adjustment application will be the current occupancy, as determined by the Division and subject to minimum occupancy requirements, if the current occupancy is different than the base year occupancy percentage.

(d) In the event that a rate adjustment is approved, the new rate will be effective for service provided from the first day of the month in which the draft findings and order were issued or following the date



the assets are actually put into service or expenses incurred, whichever is later.

(e) Approved rate adjustments will not be subject to the cap limitation pursuant to subsection 6.7.

### **8.3 Limitations 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 provider exceed the rate of payment.

## **9 EXTRAORDINARY FINANCIAL RELIEF**

Extraordinary financial relief may be available, at the discretion of the PADS, for a provider that the Division determines to be experiencing demonstrable and temporary financial difficulties. This provision does not create any entitlement to a rate in excess of that which the provider would receive under the normal operation of these rules or to any other form of relief.

(a) Based on the individual circumstances of each case, the PADs may authorize extraordinary financial relief on such conditions they shall find appropriate based on any one or a combination of the following: exemption of a program from the minimum occupancy guidelines, retroactive implementation of a rate adjustment at an earlier point in the rate period, increase in approved program costs, or such other relief as the PADs may find appropriate.

(b) After the end of the contract period, the Division shall review rates set pursuant to this subsection to determine whether revenues during the contract period

exceeded the approved program costs. To the extent that revenues exceed the approved program costs for the contract period, the Division shall apply such excess against the program's costs for the current period pursuant to V.P.N.M.I.R. §7.6, except that no allowance shall be made for excess revenues of up to five percent, and all excess revenues shall be applied unless the Division determines that such application of excess revenues would create further financial difficulties.

(c) Procedure - An application for extraordinary financial relief shall be in writing and filed with the Division. It shall be supported by such documentation as the Division may require. 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 decision, the application shall be denied, unless additional proofs are submitted.

(d) Since relief under this subsection is purely discretionary, the PADs shall not be bound in considering any prior decision made on any previous application under this subsection and decisions under this subsection shall have no precedential value either for the applicant program or for any other program.

## **10 LIMITATIONS ON PAYMENTS**

### **10.1 Contract Maximum**

Notwithstanding any other provision of these rules to the contrary, no provider shall be paid for services performed during the contract period any more than the maximum per diem rate or the maximum total amount specified in the contract.

### **10.2 Upper Payment Limits**

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(a) Medicaid payments to a provider may not exceed the upper limits established by 42 C.F.R. §447.362.

(b) The PADs reserve the right to terminate any provider contract if it determines that payments under the contract will exceed the Medicaid upper limits.

### **10.3 Lower of Rate or Charges**

At no time shall the total per diem rate for all service categories exceed the provider's customary charges to the general public for the same services.

## **11 PAYMENT FOR INTERSTATE PLACEMENTS**

### **11.1 Out-of-State Services**

(a) No reimbursement for PNMI residential child care services shall be available unless prior authorization has been granted by a PAD.

(b) The rate for preauthorized out-of-state residential child care services shall be the rate paid by the PAD or its equivalent in the state in which the facility is located.

### **11.2 In-State Services for Out-of-State Authorities**

Reimbursement shall not be made by the state of Vermont or any of its subdivisions for PNMI residential child care services provided to children placed in Vermont residential treatment programs by out-of-state child placement authorities. Support, as well as maintenance, of the child is required of the sending state as mandated by the

Interstate Compact on the Placement of Children.

## **12 ADMINISTRATIVE REVIEW AND APPEALS**

### **12.1 Draft Findings and Decisions**

(a) Before issuing findings on any desk review or audit of a funding application, request for a rate adjustment, or other request excluding extraordinary financial relief, the Division shall serve a draft of such findings or decision on the affected provider.

(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.

### **12.2 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 12.1(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 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 action.

(c) A request for an informal conference must be pursued before a request for reconsideration can be filed pursuant to subsection 12.3.

(d) Should no timely request for an informal conference be filed within the time period specified in subsection 12.2(a), the Division's draft findings and/or decision are final and no longer subject to administrative review or judicial appeal.

### **12.3 Request for Reconsideration**

(a) A provider that is aggrieved by an official action issued pursuant to subsection 12.2(b) may file a request for reconsideration.

(b) 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. Should no timely request for an informal conference be filed within the time period specified in this paragraph, the official action issued pursuant to subsection 12.2(b) is final and no longer subject to administrative review or judicial appeal.

(c) The request for reconsideration shall include 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 Publication 15, or other au-

thority 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.

(d) 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.

(e) 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.

(f) 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. Representatives of the PADs may also appear and may present evidence. The Director, or her or his designee, may hold the record open to a date certain for the receipt of additional materials.

(g) The Director shall issue a final order on the request for reconsideration no later than 30 days after the record closes.

### **12.4 Request for Administrative Review**

(a) Within 30 days of the receipt of a final order of the Division, a provider that feels aggrieved by that order may file a request for administrative review by the Secretary of the Agency of

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Human Services or a person designated by the Secretary.

(b) Proceedings under this section shall be initiated by the filing of a written request for administrative review for which forms may be prescribed by the Director. The appeal shall be filed with the Director of the Division, who, within 10 days of the receipt of the request, shall forward to the Secretary a copy of the request and the materials that represent the documentary record of the Division's action.

(c) The Secretary or the designee shall review the record of the appeal and may review such additional materials as he or she shall deem appropriate, and may, if requested by the provider, convene a hearing on no less than 10 days written notice to the provider, the Division and the PADs. Within 60 days after the close of the record, the Secretary or the designee shall issue a final determination which shall be served on the parties.

### **12.5 General Provisions**

(a) The effective date of actions or orders issued pursuant to this section shall be the effective date as set out in the Division's draft findings or decision, unless that date is at issue in the appeal.

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

## **13 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.

**AICPA:** American Institute of Certified Public Accountants.

**Allocable Cost:** A cost which is incurred for a service that is designed to achieve two or more objectives, not all of which are covered by the Medicaid program.

**Allowable Costs or Expenses:** those direct and indirect costs or expenses incurred for the provision of direct resident services and equipment used in the provision of such services. Direct resident services refers to room, board, care, rehabilitation and treatment, and may include educational services provided by programs to their residents.

**AOE:** the Vermont Agency of Education.

**Approved Program Costs:** the total allowable costs of a program in a base year.

**Adjusted Allowable Costs:** the net allowable costs of a program after the recapture of net PNMI revenue in excess of five percent.

**Base Year:** a program's fiscal year for which the allowable costs are the basis for the prospective per diem rate.

**Certified Rate:** the rate certified by the Division of Rate Setting to the PADs.

**Centers for Medicare and Medicaid Services (CMS):** Agency within the U.S. Department of Health and Human Services

(HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.

**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.

**Contract:** a provider contract is a standard form contract or standard form grant between a PAD and a Private Nonmedical Institution, which describes the services to be provided and includes the per diem rate. A provider contract pursuant to these rules does not include a contract with a residential treatment program that provides services based on individualized budgets for each child or that includes a master grant case rate or per member per month funding mechanism that is applicable for a broad array of services beyond just residential treatment services.

**Contract Period:** The twelve month period covered by the provider contract.

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

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

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

**DMH:** Department of Mental Health.

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

**Facility:** a residential treatment program, licensed as such by the Department for Children and Families' Residential Licensing and Special Investigations Unit, and enrolled in the Vermont Medicaid Program as a Private Nonmedical Institution for Child Care Services.

**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:** an action of the Division that is no longer subject to change by the Division and for which no further review or appeal is available from the Division.

**Fringe Benefits:** shall include payroll taxes, workers compensation, pension, group health, dental and life insurances, profit sharing, cafeteria plans and flexible spending plans.

**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.

**Funding Application:** A cost report prepared by the provider in accordance with instructions and on forms prescribed by the Division.

**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 market basket, home health agency market basket and regional forecasts of consumer price indexes.

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

**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.

**Interim Rate:** a prospective rate paid to a program on a temporary basis.

**Occupancy Level:** the number of paid days, including temporary absence days, as a percentage of the total permitted number of total permitted resident capacity.

**Occupancy Adjusted Per Diem:** the prior year per diem, excluding any rate adjustments, adjusted for a decline in resident days from the prior base year to the current base year, subject to minimum occupancy limits.

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

**Placement Authorizing Department (PAD):** the State governmental entity responsible (solely or in conjunction with another State entity) for authorizing the placement of a child in a residential treatment program. PADs include but are not limited to the Department for Children and Families, the Department of Mental Health, the Department of Disabilities, Aging and Independent Living, Division of Alcohol and Drug Abuse Programs or the Agency of Education in coordination with the Local Education Agency.

**Private Nonmedical Institution (PNMI):** an organization or program that is not, as a matter of regular business, a health insuring organization, hospital, nursing home, or a community health care center, that provides medical care to its residents. A Private Nonmedical Institution for Residential Child Care Services must be licensed by the Department for Children and Families' Residential Licensing and Special Investigations Unit and have a Medicaid Provider Agreement in effect with the Department of Vermont Health Access.

**Program:** a residential treatment program, licensed as such by the Department for Children and Families' Residential Licensing and Special Investigations Unit, and enrolled in the Vermont Medicaid Program as a Private Nonmedical Institution for Child Care Services.

**Provider Agreement:** a provider agreement is an agreement to provide, and receive payment for, Medicaid services according to the terms and conditions established by the PADs. A provider agreement must be in effect and on file with the Department of Vermont Health Access for an organization to be considered authorized to bill and receive payments from the Medicaid program.

**Provider Reimbursement Manual, CMS Publication 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:** an individual who is receiving services in a Private Nonmedical Institution for Residential Child Care Facility.

**Resident Day:** the care of one resident for one day of services. The day of admission is counted as one day of care, but the day of discharge is not. A resident day also includes a temporary absence day.

**Residential Treatment Program:** a private or public agency or facility that is licensed by the Department for Children and Families' Residential Licensing and Special Investigations Unit under the "Licensing Regulations for Residential Treatment Programs".

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

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

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

#### 14 TRANSITIONAL PROVISIONS

(a) The Division shall add \$500 to the state fiscal year 2014 total rate year allowable costs for each program so that programs may begin to request that their the independent public accountants prepare the PNMI sub-schedule as part of each program's next annual audit pursuant to subsection 1.7(d) and 3.2(d). If the costs for these sub-schedules are not in the programs' state fiscal rate year 2015 costs, the Division will also add \$500 to the base total allowable costs so that programs may have this PNMI sub-schedule prepared as part of the annual audit.

(b) Notwithstanding any other provisions of

### **Private Non-Medical Institutions**

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these rules, the amendments to these rules effective February 24, 2014 shall be applied to payments for services rendered on or after October 1, 2013. The base year for rates effective October 1, 2013 shall be providers' fiscal year 2012 costs.

(c) Programs shall be exempt from the penalty provisions of subsection 3.3(d) in the state fiscal year 2014 rate period.

(d) The first year that the Division shall apply the cap pursuant to subsection 6.7. is the rate year that uses base year 2014 costs.



VERMONT **GENERAL ASSEMBLY**

## The Vermont Statutes Online

### Title 33 : Human Services

#### Chapter 009 : Division Of Rate Setting

(Cite as: 33 V.S.A. § 908)

#### § 908. Powers and duties

(a) Each nursing home or other provider shall file with the Division, on request, such data, statistics, schedules, or information as the Division may require to enable it to carry out its function. Information received from a nursing home under this section shall be available to the public, except that the specific salary and wage rates of employees, other than the salary of an administrator, shall not be disclosed unless disclosure is required under 1 V.S.A. § 317(b).

(b) The Division shall have the power to examine books and accounts of any nursing home or other provider caring for State-assisted persons, to subpoena witnesses and documents, to administer oaths to witnesses, and to examine them on all matters of which the Division has jurisdiction.

(c) The Secretary shall adopt all rules and regulations necessary for the implementation of this chapter. (Added 1977, No. 204 (Adj. Sess.), § 1; amended 1995, No. 160 (Adj. Sess.), § 15; 1997, No. 131 (Adj. Sess.), § 2; 2013, No. 131 (Adj. Sess.), § 21, eff. May 20, 2014; 2015, No. 29, § 9.)

VERMONT **GENERAL ASSEMBLY**

# The Vermont Statutes Online

## Title 33 : Human Services

### Chapter 019 : Medical Assistance

#### Subchapter 001 : Medicaid

(Cite as: 33 V.S.A. § 1901)

#### § 1901. Administration of program

(a)(1) The Secretary of Human Services or designee shall take appropriate action, including making of rules, required to administer a medical assistance program under Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act.

(2) The Secretary or designee shall seek approval from the General Assembly prior to applying for and implementing a waiver of Title XIX or Title XXI of the Social Security Act, an amendment to an existing waiver, or a new state option that would restrict eligibility or benefits pursuant to the Deficit Reduction Act of 2005. Approval by the General Assembly under this subdivision constitutes approval only for the changes which are scheduled for implementation.

(3) [Repealed.]

(4) A manufacturer of pharmaceuticals purchased by individuals receiving State pharmaceutical assistance in programs administered under this chapter shall pay to the Department of Vermont Health Access, as the Secretary's designee, a rebate on all pharmaceutical claims for which State-only funds are expended in an amount that is in proportion to the State share of the total cost of the claim, as calculated annually on an aggregate basis, and based on the full Medicaid rebate amount as provided for in Section 1927(a) through (c) of the federal Social Security Act, 42 U.S.C. Section 1396r-8.

(b) [Repealed.]

(c) The Secretary may charge a monthly premium, in amounts set by the General Assembly, per family for pregnant women and children eligible for medical assistance under Sections 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII) of Title XIX of the Social Security Act, whose family income exceeds 195 percent of the federal poverty level, as permitted under section 1902(r)(2) of that act. Fees collected under this subsection shall be credited to the State Health Care Resources Fund established in section 1901d of this title and shall be available to the Agency to

offset the costs of providing Medicaid services. Any co-payments, coinsurance, or other cost sharing to be charged shall also be authorized and set by the General Assembly.

(d)(1) To enable the State to manage public resources effectively while preserving and enhancing access to health care services in the State, the Department of Vermont Health Access is authorized to serve as a publicly operated managed care organization (MCO).

(2) To the extent permitted under federal law, the Department of Vermont Health Access shall be exempt from any health maintenance organization (HMO) or MCO statutes in Vermont law and shall not be considered to be an HMO or MCO for purposes of State regulatory and reporting requirements. The MCO shall comply with the federal rules governing managed care organizations in 42 C.F.R. Part 438. The Vermont rules on the primary care case management in the Medicaid program shall be amended to apply to the MCO except to the extent that the rules conflict with the federal rules.

(3) The Agency of Human Services and Department of Vermont Health Access shall report to the Health Care Oversight Committee about implementation of Global Commitment in a manner and at a frequency to be determined by the Committee. Reporting shall, at a minimum, enable the tracking of expenditures by eligibility category, the type of care received, and to the extent possible allow historical comparison with expenditures under the previous Medicaid appropriation model (by department and program) and, if appropriate, with the amounts transferred by another department to the Department of Vermont Health Access. Reporting shall include spending in comparison to any applicable budget neutrality standards.

(e) [Repealed.]

(f) The Secretary shall not impose a prescription co-payment for individuals under age 21 enrolled in Medicaid or Dr. Dynasaur.

(g) The Department of Vermont Health Access shall post prominently on its website the total per-member per-month cost for each of its Medicaid and Medicaid waiver programs and the amount of the State's share and the beneficiary's share of such cost.

(h) To the extent required to avoid federal antitrust violations, the Department of Vermont Health Access shall facilitate and supervise the participation of health care professionals and health care facilities in the planning and implementation of payment reform in the Medicaid and SCHIP programs. The Department shall ensure that the process and implementation include sufficient State supervision

over these entities to comply with federal antitrust provisions and shall refer to the Attorney General for appropriate action the activities of any individual or entity that the Department determines, after notice and an opportunity to be heard, violate State or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods. (Added 1967, No. 147, § 6; amended 1997, No. 155 (Adj. Sess.), § 21; 2005, No. 159 (Adj. Sess.), § 2; 2005, No. 215 (Adj. Sess.), § 308, eff. May 31, 2006; 2007, No. 74, § 3, eff. June 6, 2007; 2009, No. 156 (Adj. Sess.), § E.309.15, eff. June 3, 2010; 2009, No. 156 (Adj. Sess.), § I.43; 2011, No. 48, § 16a, eff. Jan. 1, 2012; 2011, No. 139 (Adj. Sess.), § 51, eff. May 14, 2012; 2011, No. 162 (Adj. Sess.), § E.307.6; 2011, No. 171 (Adj. Sess.), § 41c; 2013, No. 79, § 23, eff. Jan. 1, 2014; 2013, No. 79, § 46; 2013, No. 131 (Adj. Sess.), § 39, eff. May 20, 2014; 2013, No. 142 (Adj. Sess.), § 98; 2017, No. 210 (Adj. Sess.), § 3, eff. June 1, 2018.)

**No. 91. An act relating to Vermont's response to COVID-19.**

(H.742)

It is hereby enacted by the General Assembly of the State of Vermont:

\* \* \* Supporting Health Care and Human Service Provider Sustainability\* \* \*

Sec. 1. AGENCY OF HUMAN SERVICES; HEALTH CARE AND HUMAN  
SERVICE PROVIDER SUSTAINABILITY

During a declared state of emergency in Vermont as a result of COVID-19, the Agency of Human Services shall consider waiving or modifying existing rules, or adopting emergency rules, to protect access to health care services, long-term services and supports, and other human services under the Agency's jurisdiction. In waiving, modifying, or adopting rules, the Agency shall consider the importance of the financial viability of providers that rely on funding from the State, federal government, or Medicaid, or a combination of these, for a major portion of their revenue.

Sec. 2. AGENCY OF HUMAN SERVICES; TEMPORARY PROVIDER  
TAX MODIFICATION AUTHORITY

(a) During a declared state of emergency in Vermont as a result of COVID-19 and for a period of six months following the termination of the state of emergency, the Secretary of Human Services may modify payment of all or a prorated portion of the assessment imposed on hospitals by 33 V.S.A. § 1953, and may waive or modify payment of all or a prorated portion of the

assessment imposed by 33 V.S.A. chapter 19, subchapter 2 for one or more other classes of health care providers, if the following two conditions are met:

(1) the action is necessary to preserve the ability of the providers to continue offering necessary health care services; and

(2) the Secretary has obtained the approval of the Joint Fiscal Committee and the Emergency Board as set forth in subsections (b) and (c) of this section.

(b)(1) If the Secretary proposes to waive or modify payment of an assessment in accordance with the authority set forth in subsection (a) of this section, the Secretary shall first provide to the Joint Fiscal Committee:

(A) the Secretary's rationale for exercising the authority, including the balance between the fiscal impact of the proposed action on the State budget and the needs of the specific class or classes of providers; and

(B) a plan for mitigating the fiscal impact to the State.

(2) Upon the Joint Fiscal Committee's approval of the plan for mitigating the fiscal impact to the State, the Secretary may waive or modify payment of the assessment as proposed unless the mitigation plan includes one or more actions requiring the approval of the Emergency Board.

(c)(1) If the mitigation plan includes one or more actions requiring the approval of the Emergency Board, the Secretary shall obtain the Emergency Board's approval for the action or actions prior to waiving or modifying payment of the assessment.

(2) Upon the Emergency Board's approval of the action or actions, the Secretary may waive or modify payment of the assessment as proposed.

\* \* \* Protections for Employees of Health Care Facilities  
and Human Service Providers \* \* \*

Sec. 3. PROTECTIONS FOR EMPLOYEES OF HEALTH CARE  
FACILITIES AND HUMAN SERVICE PROVIDERS

In order to protect employees of a health care facility or human service provider who are not licensed health care professionals from the risks associated with COVID-19, all health care facilities and human service providers in Vermont, including hospitals, federally qualified health centers, rural health clinics, residential treatment programs, homeless shelters, home- and community-based service providers, and long-term care facilities, shall follow guidance from the Vermont Department of Health regarding measures to address employee safety, to the extent feasible.

\* \* \* Compliance Flexibility \* \* \*

Sec. 4. HEALTH CARE AND HUMAN SERVICE PROVIDER  
REGULATION; WAIVER OR VARIANCE PERMITTED

Notwithstanding any provision of the Agency of Human Services' administrative rules or standards to the contrary, during a declared state of emergency in Vermont as a result of COVID-19, the Secretary of Human Services may waive or permit variances from the following State rules and standards governing providers of health care services and human services as

necessary to prioritize and maximize direct patient care, support children and families who receive benefits and services through the Department for Children and Families, and allow for continuation of operations with a reduced workforce and with flexible staffing arrangements that are responsive to evolving needs, to the extent such waivers or variances are permitted under federal law:

(1) Hospital Licensing Rule;

(2) Hospital Reporting Rule;

(3) Nursing Home Licensing and Operating Rule;

(4) Home Health Agency Designation and Operation Regulations;

(5) Residential Care Home Licensing Regulations;

(6) Assisted Living Residence Licensing Regulations;

(7) Home for the Terminally Ill Licensing Regulations;

(8) Standards for Adult Day Services;

(9) Therapeutic Community Residences Licensing Regulations;

(10) Choices for Care High/Highest Manual;

(11) Designated and Specialized Service Agency designation and

provider rules;

(12) Child Care Licensing Regulations;

(13) Public Assistance Program Regulations;

(14) Foster Care and Residential Program Regulations; and



(15) other rules and standards for which the Agency of Human Services is the adopting authority under 3 V.S.A. chapter 25.

Sec. 5. GREEN MOUNTAIN CARE BOARD RULES; WAIVER OR  
VARIANCE PERMITTED

Notwithstanding any provision of 18 V.S.A. chapter 220 or 221, 8 V.S.A. § 4062, 33 V.S.A. chapter 18, subchapter 1, or the Green Mountain Care Board's administrative rules, guidance, or standards to the contrary, during a declared state of emergency in Vermont as a result of COVID-19 and for a period of six months following the termination of the state of emergency, the Green Mountain Care Board may waive or permit variances from State laws, guidance, and standards with respect to the following regulatory activities, to the extent permitted under federal law, as necessary to prioritize and maximize direct patient care, safeguard the stability of health care providers, and allow for orderly regulatory processes that are responsive to evolving needs related to the COVID-19 pandemic:

- (1) hospital budget review;
- (2) certificates of need;
- (3) health insurance rate review; and
- (4) accountable care organization certification and budget review.

Sec. 6. MEDICAID AND HEALTH INSURERS; PROVIDER

ENROLLMENT AND CREDENTIALING

During a declared state of emergency in Vermont as a result of COVID-19, to the extent permitted under federal law, the Department of Vermont Health Access shall relax provider enrollment requirements for the Medicaid program, and the Department of Financial Regulation shall direct health insurers to relax provider credentialing requirements for health insurance plans, in order to allow for individual health care providers to deliver and be reimbursed for services provided across health care settings as needed to respond to Vermonters' evolving health care needs.

Sec. 7. INVOLUNTARY TREATMENT; DOCUMENTATION AND

REPORTING REQUIREMENTS; WAIVER PERMITTED

(a) Notwithstanding any provision of statute or rule to the contrary, during a declared state of emergency in Vermont as a result of COVID-19, the court or the Department of Mental Health may waive any financial penalties associated with a treating health care provider's failure to comply with one or more of the documentation and reporting requirements related to involuntary treatment pursuant to 18 V.S.A. chapter 181, to the extent permitted under federal law.

(b) Nothing in this section shall be construed to suspend or waive any of the requirements in 18 V.S.A. chapter 181 relating to judicial proceedings for involuntary treatment and medication.

\* \* \* Access to Health Care Services and Human Services \* \* \*

Sec. 8. ACCESS TO HEALTH CARE SERVICES; DEPARTMENT OF  
FINANCIAL REGULATION; EMERGENCY RULEMAKING

It is the intent of the General Assembly to increase Vermonters' access to medically necessary health care services during a declared state of emergency in Vermont as a result of COVID-19. During such a declared state of emergency, the Department of Financial Regulation shall consider adopting, and shall have the authority to adopt, emergency rules to address the following for the duration of the state of emergency:

(1) expanding health insurance coverage for, and waiving or limiting cost-sharing requirements directly related to, COVID-19 diagnosis, treatment, and prevention;

(2) modifying or suspending health insurance plan deductible requirements for all prescription drugs, except to the extent that such an action would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223; and

(3) expanding patients' access to and providers' reimbursement for health care services, including preventive services, consultation services, and services to new patients, delivered remotely through telehealth, audio-only telephone, and brief telecommunication services.

Sec. 9. PRESCRIPTION DRUGS; MAINTENANCE MEDICATIONS;

EARLY REFILLS

(a) As used in this section, “health insurance plan” means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402. The term does not include policies or plans providing coverage for a specified disease or other limited benefit coverage.

(b) During a declared state of emergency in Vermont as a result of COVID-19, all health insurance plans and Vermont Medicaid shall allow their members to refill prescriptions for chronic maintenance medications early to enable the members to maintain a 30-day supply of each prescribed maintenance medication at home.

(c) As used in this section, “maintenance medication” means a prescription drug taken on a regular basis over an extended period of time to treat a chronic or long-term condition. The term does not include a regulated drug, as defined in 18 V.S.A. § 4201.

Sec. 10. PHARMACISTS; CLINICAL PHARMACY; EXTENSION OF

PRESCRIPTION FOR MAINTENANCE MEDICATION

(a) During a declared state of emergency in Vermont as a result of COVID-19, a pharmacist may extend a previous prescription for a maintenance medication for which the patient has no refills remaining or for which the authorization for refills has recently expired if it is not feasible to obtain a new prescription or refill authorization from the prescriber.

(b) A pharmacist who extends a prescription for a maintenance medication pursuant to this section shall take all reasonable measures to notify the prescriber of the prescription extension in a timely manner.

(c) As used in this section, “maintenance medication” means a prescription drug taken on a regular basis over an extended period of time to treat a chronic or long-term condition. The term does not include a regulated drug, as defined in 18 V.S.A. § 4201.

#### Sec. 11. PHARMACISTS; CLINICAL PHARMACY; THERAPEUTIC

##### SUBSTITUTION DUE TO LACK OF AVAILABILITY

(a) During a declared state of emergency in Vermont as a result of COVID-19, a pharmacist may, with the informed consent of the patient, substitute an available drug or insulin product for an unavailable prescribed drug or insulin product in the same therapeutic class if the available drug or insulin product would, in the clinical judgment of the pharmacist, have substantially equivalent therapeutic effect even though it is not a therapeutic equivalent.

(b) As soon as reasonably possible after substituting a drug or insulin product pursuant to subsection (a) of this section, the pharmacist shall notify the prescribing clinician of the drug or insulin product, dose, and quantity actually dispensed to the patient.

#### Sec. 12. BUPRENORPHINE; PRESCRIPTION RENEWALS

During a declared state of emergency in Vermont as a result of COVID-19, to the extent permitted under federal law, a health care professional authorized

to prescribe buprenorphine for treatment of substance use disorder may authorize renewal of a patient's existing buprenorphine prescription without requiring an office visit.

Sec. 13. 24-HOUR FACILITIES AND PROGRAMS; BED-HOLD DAYS

During a declared state of emergency in Vermont as a result of COVID-19, to the extent permitted under federal law, the Agency of Human Services may reimburse Medicaid-funded long-term care facilities and other programs providing 24-hour per day services for their bed-hold days.

\* \* \* Regulation of Professions \* \* \*

Sec. 14. 3 V.S.A. § 129 is amended to read:

§ 129. POWERS OF BOARDS; DISCIPLINE PROCESS

(a) In addition to any other provisions of law, a board may exercise the following powers:

\* \* \*

(10)(A) Issue temporary licenses during a declared state of emergency.

The person to be issued a temporary license must be:

(i) currently licensed, in good standing, and not subject to disciplinary proceedings in any other jurisdiction; or

(ii) a graduate of an approved education program during a period when licensing examinations are not reasonably available.

(B) The temporary license shall authorize the holder to practice in Vermont until the termination of the declared state of emergency or 90 days,

whichever occurs first, as long as provided the licensee remains in good standing, and may be reissued by the board if the declared state of emergency continues longer than 90 days.

(C) Fees shall be waived when a license is required to provide services under this subdivision.

\* \* \*

Sec. 15. 26 V.S.A. § 1353 is amended to read:

§ 1353. POWERS AND DUTIES OF THE BOARD

The Board shall have the following powers and duties to:

\* \* \*

(11) During a declared state of emergency:

(A) The Board or the Executive Director of the Board may issue a temporary license to an individual who is currently licensed to practice as a physician, physician assistant, or podiatrist in another jurisdiction, whose license is in good standing, and who is not subject to disciplinary proceedings in any other jurisdiction. The temporary license shall authorize the holder to practice in Vermont until the termination of the declared state of emergency or 90 days, whichever occurs first, provided the licensee remains in good standing, and may be reissued by the Board if the declared state of emergency continues longer than 90 days. Fees shall be waived when a license is required to provide services under this subdivision (A).

(B) The Board or the Executive Director of the Board may waive supervision and scope of practice requirements for physician assistants, including the requirement for documentation of the relationship between a physician assistant and a physician pursuant to section 1735a of this title. The Board or Executive Director may impose limitations or conditions when granting a waiver under this subdivision (B).

Sec. 16. 26 V.S.A. § 1613 is amended to read:

§ 1613. TRANSITION TO PRACTICE

\* \* \*

(c) The Board may waive or modify the collaborative provider agreement requirement as necessary to allow an APRN to practice independently during a declared state of emergency.

Sec. 17. OFFICE OF PROFESSIONAL REGULATION; BOARD OF  
MEDICAL PRACTICE; OUT-OF-STATE HEALTH CARE  
PROFESSIONALS

(a) Notwithstanding any provision of Vermont's professional licensure statutes or rules to the contrary, during a declared state of emergency in Vermont as a result of COVID-19, a health care professional, including a mental health professional, who holds a valid license, certificate, or registration to provide health care services in any other U.S. jurisdiction shall be deemed to be licensed, certified, or registered to provide health care services, including



mental health services, to a patient located in Vermont using telehealth or as part of the staff of a licensed facility, provided the health care professional:

(1) is licensed, certified, or registered in good standing in the other U.S. jurisdiction or jurisdictions in which the health care professional holds a license, certificate, or registration;

(2) is not subject to any professional disciplinary proceedings in any other U.S. jurisdiction; and

(3) is not affirmatively barred from practice in Vermont for reasons of fraud or abuse, patient care, or public safety.

(b) A health care professional who plans to provide health care services in Vermont as part of the staff of a licensed facility shall submit or have submitted on the individual's behalf the individual's name, contact information, and the location or locations at which the individual will be practicing to:

(1) the Board of Medical Practice for medical doctors, physician assistants, and podiatrists; or

(2) the Office of Professional Regulation for all other health care professions.

(c) A health care professional who delivers health care services in Vermont pursuant to subsection (a) of this section shall be subject to the imputed jurisdiction of the Board of Medical Practice or the Office of Professional

Regulation, as applicable based on the health care professional's profession, in accordance with Sec. 19 of this act.

(d) This section shall remain in effect until the termination of the declared state of emergency in Vermont as a result of COVID-19 and provided the health care professional remains licensed, certified, or registered in good standing.

Sec. 18. RETIRED HEALTH CARE PROFESSIONALS; BOARD OF  
MEDICAL PRACTICE; OFFICE OF PROFESSIONAL  
REGULATION

(a)(1) During a declared state of emergency in Vermont as a result of COVID-19, a former health care professional, including a mental health professional, who retired not more than three years earlier with the individual's Vermont license, certificate, or registration in good standing may provide health care services, including mental health services, to a patient located in Vermont using telehealth or as part of the staff of a licensed facility after submitting, or having submitted on the individual's behalf, to the Board of Medical Practice or Office of Professional Regulation, as applicable, the individual's name, contact information, and the location or locations at which the individual will be practicing.

(2) A former health care professional who returns to the Vermont health care workforce pursuant to this subsection shall be subject to the regulatory

jurisdiction of the Board of Medical Practice or the Office of Professional Regulation, as applicable.

(b) During a declared state of emergency in Vermont as a result of COVID-19, the Board of Medical Practice and the Office of Professional Regulation may permit former health care professionals, including mental health professionals, who retired more than three but less than 10 years earlier with their Vermont license, certificate, or registration in good standing to return to the health care workforce on a temporary basis to provide health care services, including mental health services, to patients in Vermont. The Board of Medical Practice and Office of Professional Regulation may issue temporary licenses to these individuals at no charge and may impose limitations on the scope of practice of returning health care professionals as the Board or Office deems appropriate.

Sec. 19. OFFICE OF PROFESSIONAL REGULATION; BOARD OF  
MEDICAL PRACTICE; IMPUTED JURISDICTION

A practitioner of a profession or professional activity regulated by Title 26 of the Vermont Statutes Annotated who provides regulated professional services to a patient in the State of Vermont without holding a Vermont license, as may be authorized in a declared state of emergency, is deemed to consent to, and shall be subject to, the regulatory and disciplinary jurisdiction of the Vermont regulatory agency or body having jurisdiction over the regulated profession or professional activity.

Sec. 20. OFFICE OF PROFESSIONAL REGULATION; BOARD OF  
MEDICAL PRACTICE; EMERGENCY AUTHORITY TO ACT  
FOR REGULATORY BOARDS

(a)(1) During a declared state of emergency in Vermont as a result of COVID-19, if the Director of Professional Regulation finds that a regulatory body attached to the Office of Professional Regulation by 3 V.S.A. § 122 cannot reasonably, safely, and expeditiously convene a quorum to transact business, the Director may exercise the full powers and authorities of that regulatory body, including disciplinary authority.

(2) During a declared state of emergency in Vermont as a result of COVID-19, if the Executive Director of the Board of Medical Practice finds that the Board cannot reasonably, safely, and expeditiously convene a quorum to transact business, the Executive Director may exercise the full powers and authorities of the Board, including disciplinary authority.

(b) The signature of the Director of the Office of Professional Regulation or of the Executive Director of the Board of Medical Practice shall have the same force and effect as a voted act of their respective boards.

(c)(1) A record of the actions of the Director of the Office of Professional Regulation taken pursuant to the authority granted by this section shall be published conspicuously on the website of the regulatory body on whose behalf the Director took the action.

(2) A record of the actions of the Executive Director of the Board of Medical Practice taken pursuant to the authority granted by this section shall be published conspicuously on the website of the Board of Medical Practice.

Sec. 21. OFFICE OF PROFESSIONAL REGULATION; BOARD OF

MEDICAL PRACTICE; EMERGENCY REGULATORY ORDERS

During a declared state of emergency in Vermont as a result of COVID-19, the Director of Professional Regulation and the Commissioner of Health may issue such orders governing regulated professional activities and practices as may be necessary to protect the public health, safety, and welfare. If the Director or Commissioner finds that a professional practice, act, offering, therapy, or procedure by persons licensed or required to be licensed by Title 26 of the Vermont Statutes Annotated is exploitative, deceptive, or detrimental to the public health, safety, or welfare, or a combination of these, the Director or Commissioner may issue an order to cease and desist from the applicable activity, which, after reasonable efforts to publicize or serve the order on the affected persons, shall be binding upon all persons licensed or required to be licensed by Title 26 of the Vermont Statutes Annotated, and a violation of the order shall subject the person or persons to professional discipline, may be a basis for injunction by the Superior Court, and shall be deemed a violation of 3 V.S.A. § 127.

\* \* \* Quarantine and Isolation for COVID-19 as Exception  
to Seclusion \* \* \*

Sec. 22. ISOLATION OR QUARANTINE FOR COVID-19 NOT  
SECLUSION

(a) Notwithstanding any provision of statute or rule to the contrary, it shall not be considered the emergency involuntary procedure of seclusion for a voluntary patient, or for an involuntary patient in the care and custody of the Commissioner of Mental Health, to be placed in quarantine if the patient has been exposed to COVID-19 or in isolation if the patient has tested positive for COVID-19.

(b) Notwithstanding any provision of statute or rule to the contrary, it shall not be considered seclusion, as defined in the Department for Children and Families' Licensing Regulations for Residential Treatment Programs in Vermont, for a child in a residential treatment facility to be placed in quarantine if the child has been exposed to COVID-19 or in isolation if the child has tested positive for COVID-19.

\* \* \* Telehealth \* \* \*

Sec. 23. TELEHEALTH EXPANSION; LEGISLATIVE INTENT

It is the intent of the General Assembly to increase Vermonters' access to health care services through an expansion of telehealth services without increasing social isolation or supplanting the role of local, community-based health care providers throughout rural Vermont.

Sec. 24. 8 V.S.A. § 4100k is amended to read:

§ 4100k. COVERAGE OF HEALTH CARE SERVICES DELIVERED  
THROUGH TELEMEDICINE AND BY STORE-AND-  
FORWARD MEANS

(a)(1) All health insurance plans in this State shall provide coverage for health care services and dental services delivered through telemedicine by a health care provider at a distant site to a patient at an originating site to the same extent that the plan would cover the services if they were provided through in-person consultation.

(2)(A) A health insurance plan shall provide the same reimbursement rate for services billed using equivalent procedure codes and modifiers, subject to the terms of the health insurance plan and provider contract, regardless of whether the service was provided through an in-person visit with the health care provider or through telemedicine.

(B) The provisions of subdivision (A) of this subdivision (2) shall not apply to services provided pursuant to the health insurance plan's contract with a third-party telemedicine vendor to provide health care or dental services.

(b) A health insurance plan may charge a deductible, co-payment, or coinsurance for a health care service or dental service provided through telemedicine ~~so~~ as long as it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(c) A health insurance plan may limit coverage to health care providers in the plan's network. A health insurance plan shall not impose limitations on the number of telemedicine consultations a covered person may receive that exceed limitations otherwise placed on in-person covered services.

(d) Nothing in this section shall be construed to prohibit a health insurance plan from providing coverage for only those services that are medically necessary and are clinically appropriate for delivery through telemedicine, subject to the terms and conditions of the covered person's policy.

~~(e) A health insurance plan may reimburse for teleophthalmology or teledermatology provided by store and forward means and may require the distant site health care provider to document the reason the services are being provided by store and forward means.~~

(1) A health insurance plan shall reimburse for health care services and dental services delivered by store-and-forward means.

(2) A health insurance plan shall not impose more than one cost-sharing requirement on a patient for receipt of health care services or dental services delivered by store-and-forward means. If the services would require cost-sharing under the terms of the patient's health insurance plan, the plan may impose the cost-sharing requirement on the services of the originating site health care provider or of the distant site health care provider, but not both.

(f) A health insurer shall not construe a patient's receipt of services delivered through telemedicine or by store-and-forward means as limiting in



any way the patient's ability to receive additional covered in-person services from the same or a different health care provider for diagnosis or treatment of the same condition.

(g) Nothing in this section shall be construed to require a health insurance plan to reimburse the distant site health care provider if the distant site health care provider has insufficient information to render an opinion.

(g)(h) In order to facilitate the use of telemedicine in treating substance use disorder, when the originating site is a health care facility, health insurers and the Department of Vermont Health Access shall ensure that the health care provider at the distant site and the health care facility at the originating site are both reimbursed for the services rendered, unless the health care providers at both the distant and originating sites are employed by the same entity.

(h)(i) As used in this subchapter:

\* \* \*

(2) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402, ~~as well as; a stand-alone dental plan or policy or other dental insurance plan offered by a dental insurer; and~~ Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State. The term does not include policies or plans providing coverage for a specified disease or other limited benefit coverage.

\* \* \*

(4) “Health care provider” means a person, partnership, or corporation, other than a facility or institution, that is licensed, certified, or otherwise authorized by law to provide professional health care services, including dental services, in this State to an individual during that individual’s medical care, treatment, or confinement.

\* \* \*

(6) “Store and forward” means an asynchronous transmission of medical information, such as one or more video clips, audio clips, still images, x-rays, magnetic resonance imaging scans, electrocardiograms, electroencephalograms, or laboratory results, sent over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104–191 to be reviewed at a later date by a health care provider at a distant site who is trained in the relevant specialty ~~and by which~~. In store and forward, the health care provider at the distant site reviews the medical information without the patient present in real time and communicates a care plan or treatment recommendation back to the patient or referring provider, or both.

(7) “Telemedicine” means the delivery of health care services, including dental services, such as diagnosis, consultation, or treatment through the use of live interactive audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of

1996, ~~Public Law Pub. L. No. 104-191. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile.~~

Sec. 25. 18 V.S.A. § 9361 is amended to read:

§ 9361. HEALTH CARE PROVIDERS DELIVERING HEALTH CARE SERVICES THROUGH TELEMEDICINE OR BY ~~STORE AND FORWARD~~ STORE-AND-FORWARD MEANS

\* \* \*

(c)(1) A health care provider delivering health care services or dental services through telemedicine shall obtain and document a patient's oral or written informed consent for the use of telemedicine technology prior to delivering services to the patient.

(A) The informed consent for telemedicine services shall be provided in accordance with Vermont and national policies and guidelines on the appropriate use of telemedicine within the provider's profession and shall include, in language that patients can easily understand:

(i) an explanation of the opportunities and limitations of delivering health care services or dental services through telemedicine;

(ii) informing the patient of the presence of any other individual who will be participating in or observing the patient's consultation with the provider at the distant site and obtaining the patient's permission for the participation or observation; and

(iii) assurance that all services the health care provider delivers to the patient through telemedicine will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

\* \* \*

~~(e) A patient receiving teleophthalmology or teledermatology by store and forward means shall be informed of the right to receive a consultation with the distant site health care provider and shall receive a consultation with the distant site health care provider upon request. If requested, the consultation with the distant site health care provider may occur either at the time of the initial consultation or within a reasonable period of time following the patient's notification of the results of the initial consultation. Receiving teledermatology or teleophthalmology by store and forward means.~~

(1) A patient receiving health care services or dental services by store-and-forward means shall be informed of the patient's right to refuse to receive services in this manner and to request services in an alternative format, such as through real-time telemedicine services or an in-person visit.

(2) Receipt of services by store-and-forward means shall not preclude a patient from receiving real-time telemedicine or face-to-face services or an in-person visit with the distant site health care provider at a future date.

(3) Originating site health care providers involved in the ~~store and forward~~ store-and-forward process shall obtain informed consent from the patient as described in subsection (c) of this section.

Sec. 26. WAIVER OF CERTAIN TELEHEALTH REQUIREMENTS  
DURING STATE OF EMERGENCY

Notwithstanding any provision of 8 V.S.A. § 4100k or 18 V.S.A. § 9361 to the contrary, during a declared state of emergency in Vermont as a result of COVID-19, the following provisions related to the delivery of health care services through telemedicine or by store-and-forward means shall not be required, to the extent their waiver is permitted by federal law:

(1) delivering health care services, including dental services, using a connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 in accordance with 8 V.S.A. § 4100k(i), as amended by this act, if it is not practicable to use such a connection under the circumstances;

(2) representing to a patient that the health care services, including dental services, will be delivered using a connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 in accordance with 18 V.S.A. § 9361(c), if it is not practicable to use such a connection under the circumstances; and

(3) obtaining and documenting a patient's oral or written informed consent for the use of telemedicine or store-and-forward technology prior to

delivering services to the patient in accordance with 18 V.S.A. § 9361(c), if obtaining or documenting such consent, or both, is not practicable under the circumstances.

Sec. 27. TELEMEDICINE REIMBURSEMENT; SUNSET

8 V.S.A. § 4100k(a)(2) (telemedicine reimbursement) is repealed on January 1, 2026.

\* \* \* Child Care Programs; Extraordinary Financial Relief \* \* \*

Sec. 28. SUPPLEMENTAL CHILD CARE GRANTS; TEMPORARY  
SUSPENSION OF CAP

Notwithstanding the provision in 33 V.S.A. § 3505(a) that enables the Commissioner for Children and Families to reserve not more than one-half of one percent of the Child Care Financial Assistance Program (CCFAP) appropriation for extraordinary financial relief to assist child care programs that are at risk of closing due to financial hardship, the Commissioner may direct a greater percentage of the fiscal year 2020 CCFAP appropriation for this purpose while the state of emergency related to COVID-19 is in effect.

\* \* \* Unemployment Insurance \* \* \*

Sec. 29. 21 V.S.A. § 1314a is amended to read:

§ 1314a. QUARTERLY WAGE REPORTING; MISCLASSIFICATION;  
PENALTIES

(a)(1) ~~Effective with the calendar quarter ending September 30, 1986 and all subsequent calendar quarters, each~~ Each employing unit ~~which that~~ is an

employer ~~as defined in subdivision 1301(5) of this chapter,~~ having that has individuals in employment as defined in subdivision 1301(6) of this chapter, shall file with the Commissioner on forms ~~to be~~ supplied by the Commissioner ~~to each such employer~~ a detailed wage report ~~containing~~ for each calendar quarter that contains each individual worker's name, Social Security number, gross wages paid during each ~~such~~ calendar quarter, and any other information the Commissioner deems ~~reasonably~~ necessary in the administration of this chapter.

(2) ~~Effective with the calendar quarter ending March 31, 2001, and all subsequent calendar quarters, in~~ In addition to other information required by this section, the wage reports required by this subsection shall include for each worker paid by the hour, the worker's gender, and the worker's hourly wage. ~~The wage reports may be filed electronically.~~

\* \* \*

(c) An employing unit, ~~as defined in subdivision 1301(4) of this chapter~~ which that is not an employer, ~~as defined in subdivision 1301(5),~~ shall, upon request of the Commissioner, ~~file~~ submit reports on forms furnished by the Commissioner ~~reports respecting~~ regarding employment, wages, hours of employment, and unemployment, and related matters as that the Commissioner deems ~~reasonably~~ necessary in the administration of this chapter.

(d) Reports required by subsection (c) of this section shall be ~~returned so as to be received by~~ submitted to the Commissioner not later than 10 calendar

days after the date of the mailing of the Commissioner's request was mailed to the employing unit.

(e) On the request of the Commissioner, any employing unit or employer shall report, within 10 days of the mailing or personal delivery of the request, separation information ~~with respect to~~ for a claimant, any disqualifying income the claimant may have received, and any other information that the Commissioner may ~~reasonably~~ require to determine a the claimant's eligibility for unemployment compensation. The Commissioner shall make ~~such~~ a request ~~whenever~~ when:

(1) the claimant's eligibility is dependent either upon:

(A) wages paid during an incomplete calendar quarter in which the claimant was separated; or

(B) upon the last completed quarter; and

(2) ~~when to do so would~~ obtaining the information will result in more timely benefit payments.

(f)(1) Any employing unit or employer that fails to:

(A) File ~~any~~ a report required by this section shall be subject to a an administrative penalty of \$100.00 for each report not received by the prescribed due dates.

(B) Properly classify an individual regarding the status of employment ~~is~~ shall be subject to a an administrative penalty of not more than \$5,000.00 for each improperly classified employee. In addition, an employer



found to have violated this section is prohibited from contracting, directly or indirectly, with the State or any of its subdivisions for up to three years following the date the employer was found to have failed to properly classify, as determined by the Commissioner in consultation with the Commissioner of Buildings and General Services or the Secretary of Transportation, as appropriate. Either the Secretary or the Commissioner, as appropriate, shall be consulted in any appeal relating to prohibiting the employer from contracting with the State or its subdivisions.

(2)(A) Penalties under this subsection shall be collected in the same manner ~~provided for the collection of~~ as contributions ~~in~~ under section 1329 of this title and shall be paid into the Contingent Fund ~~provided~~ established in section 1365 of this title.

(B) If the employing unit demonstrates that its failure was due to a reasonable cause, the Commissioner may waive or reduce the penalty.

(g)(1) Notwithstanding any other provisions of this section, the Commissioner may where practicable require ~~of~~ any employing unit ~~that~~ to file the reports required ~~to be filed~~ pursuant to subsections (a) through (d) of this section ~~be filed~~, or any departmental registration required prior to submitting the reports required by this section, in an electronic media form.

(2) The Commissioner may waive the requirement that an employing unit submit a report in an electronic media form if the employing unit attests that it is unable to file the required report in that form.

\* \* \* Unemployment Insurance Related to COVID-19 Outbreak \* \* \*

Sec. 30. 21 V.S.A. § 1325 is amended to read:

§ 1325. EMPLOYERS' EXPERIENCE-RATING RECORDS;

DISCLOSURE TO SUCCESSOR ENTITY

(a)(1) The Commissioner shall maintain an experience-rating record for each employer. Benefits paid shall be charged against the experience-rating record of each subject employer who provided base-period wages to the eligible individual. Each subject employer's experience-rating charge shall bear the same ratio to total benefits paid as the total base-period wages paid by that employer bear to the total base-period wages paid to the individual by all base-period employers. The experience-rating record of an individual subject base-period employer shall not be charged for benefits paid to an individual under any of the following conditions:

\* \* \*

(G) The individual voluntarily separated from that employer as provided by subdivision 1344(a)(2)(A) of this chapter for one of the following reasons:

(i) to self-isolate or quarantine at the recommendation of a health care provider or pursuant to a specific recommendation, directive, or order issued by a public health authority with jurisdiction, the Governor, or the President for one of the following reasons:

(I) the individual has been diagnosed with COVID-19;

(II) the individual is experiencing the symptoms of COVID-19;  
(III) the individual has been exposed to COVID-19; or  
(IV) the individual belongs to a specific class or group of persons that have been identified as being at high-risk if exposed to or infected with COVID-19;

(ii) because of an unreasonable risk that the individual could be exposed to or become infected with COVID-19 at the individual's place of employment;

(iii) to care for or assist a family member of the individual who is self-isolating or quarantining at the recommendation of a health care provider or pursuant to a specific recommendation, directive, or order issued by a public health authority with jurisdiction, the Governor, or the President for one of the following reasons:

(I) the family member has been diagnosed with COVID-19;  
(II) the family member is experiencing the symptoms of COVID-19;  
(III) the family member has been exposed to COVID-19; or  
(IV) the family member belongs to a specific class or group of persons that have been identified as being at high-risk if exposed to or infected with COVID-19;

(iv) to care for or assist a family member who has left employment because of an unreasonable risk that they could be exposed to or become infected with COVID-19 at their place of employment; or

(v) to care for a child under 18 years of age because the child's school or child care has been closed or the child care provider is unavailable due to a public health emergency related to COVID-19.

(H) As used in this subdivision (a)(1):

(i) "Family member" means an individual's parent, grandparent, spouse, child, brother, sister, parent-in-law, grandchild, or foster child. As used in this subdivision (a)(1)(H)(i), "spouse" includes a domestic partner or civil union partner.

(ii) "An unreasonable risk that the individual could be exposed to or become infected with COVID-19 at the individual's place of employment" shall include the individual's place of employment being out of compliance with the Guidance on Preparing Workplaces for COVID-19 issued by the U.S. Occupational Safety and Health Administration (OSHA) or any similar guidance issued by OSHA, the U.S. Centers for Disease Control, or the Vermont Department of Health and any other conditions or factors that the Commissioner determines to create an unreasonable risk.

(2) If an individual's unemployment is directly caused by a major disaster declared by the President of the United States pursuant to 42 U.S.C. § 5122 and the individual would have been eligible for federal disaster

unemployment assistance benefits but for the receipt of regular benefits, an employer shall be relieved of charges for benefits paid to the individual with respect to any week of unemployment occurring due to the natural disaster up to a maximum amount of four weeks.

(3)(A) Subject to the provisions of subdivision (B) of this subdivision (a)(3), an employer shall be relieved of charges for benefits paid to an individual for a period of up to eight weeks with respect to benefits paid because:

(i) the employer temporarily ceased operation, either partially or completely, at the individual's place of employment in response to a request from a public health authority with jurisdiction that the employer cease operations because of COVID-19, in response to an emergency order or directive issued by the Governor or the President related to COVID-19, or because the employer voluntarily ceased operations due to the actual exposure of workers at that place of employment to COVID-19;

(ii) the individual becomes unemployed as a direct result of a state of emergency declared by the Governor or the President in relation to COVID-19 or an order or directive issued by the Governor or President in relation to COVID-19; or

(iii) the individual has been recommended or requested by a medical professional or a public health authority with jurisdiction to be isolated

or quarantined as a result of COVID-19, regardless of whether the individual has been diagnosed with COVID-19.

(B) An employer shall only be eligible for relief of charges for benefits paid under the provisions of this subdivision (a)(3) if the employer rehires or offers to rehire the individual within a reasonable period of time after the employer resumes operations at the individual's place of employment, as determined by the Commissioner, or upon the completion of the individual's period of isolation or quarantine.

(C) The Commissioner may extend the period for which an employer shall be relieved of charges for benefits paid to employees pursuant to subdivision (A)(i) of this subdivision (a)(3) by an amount that the Commissioner determines to be appropriate in light of the terms of any applicable request from a local health official or the Commissioner of Health or any applicable emergency order or directive issued by the Governor or the President and any other relevant conditions or factors.

\* \* \*

Sec. 31. 21 V.S.A. § 1344 is amended to read:

§ 1344. DISQUALIFICATIONS

(a) An individual shall be disqualified for benefits:

\* \* \*

(2) For any week benefits are claimed, except as provided in subdivision (a)(3) of this section, until he or she has presented evidence to the satisfaction

of the Commissioner that he or she has performed services in employment for a bona fide employer and has had earnings in excess of six times his or her weekly benefit amount if the Commissioner finds that such individual is unemployed because:

(A) He or she has left the employ of his or her last employing unit voluntarily without good cause attributable to such employing unit. An individual shall not suffer more than one disqualification by reason of such separation. However, an individual shall not be disqualified for benefits if:

(i) the individual left such employment to accompany a spouse who:

~~(i)~~(I) is on active duty with the U.S. Armed Forces and is required to relocate due to permanent change of station orders, activation orders, or unit deployment orders, and when such relocation would make it impractical or impossible, as determined by the Commissioner, for the individual to continue working for such employing unit; or

~~(ii)~~(II) holds a commission in the U.S. Foreign Service and is assigned overseas, and when such relocation would make it impractical or impossible, as determined by the Commissioner, for the individual to continue working for such employing unit;

(ii) the individual has left employment to self-isolate or quarantine at the recommendation of a health care provider or pursuant to a specific

recommendation, directive, or order issued by a public health authority with jurisdiction, the Governor, or the President for one of the following reasons:

(I) the individual has been diagnosed with COVID-19;

(II) the individual is experiencing the symptoms of COVID-19;

(III) the individual has been exposed to COVID-19; or

(IV) the individual belongs to a specific class or group of persons that have been identified as being at high-risk if exposed to or infected with COVID-19;

(iii) the individual has left employment because of an unreasonable risk that the individual could be exposed to or become infected with COVID-19 at the individual's place of employment;

(iv) the individual has left employment to care for or assist a family member of the individual who is self-isolating or quarantining at the recommendation of a health care provider or pursuant to a specific recommendation, directive, or order issued by a public health authority with jurisdiction, the Governor, or the President for one of the following reasons:

(I) the family member has been diagnosed with COVID-19;

(II) the family member is experiencing the symptoms of COVID-19;

(III) the family member has been exposed to COVID-19; or



(IV) the family member belongs to a specific class or group of persons that have been identified as being at high-risk if exposed to or infected with COVID-19;

(v) the individual has left employment to care for or assist a family member who has left employment because of an unreasonable risk that they could be exposed to or become infected with COVID-19 at their place of employment; or

(vi) the individual left employment to care for a child under 18 years of age because the child's school or child care has been closed or the child care provider is unavailable due to a public health emergency related to COVID-19.

\* \* \*

(G) As used in this subdivision (a)(2):

(i) "Family member" means an individual's parent, grandparent, spouse, child, brother, sister, parent-in-law, grandchild, or foster child. As used in this subdivision (a)(2)(G)(i), "spouse" includes a domestic partner or civil union partner.

(ii) "An unreasonable risk that the individual could be exposed to or become infected with COVID-19 at the individual's place of employment" shall include the individual's place of employment being out of compliance with the Guidance on Preparing Workplaces for COVID-19 issued by the U.S. Occupational Safety and Health Administration (OSHA) or any similar

guidance issued by OSHA, the U.S. Centers for Disease Control, or the Vermont Department of Health and any other conditions or factors that the Commissioner determines to create an unreasonable risk.

(H)(i) Except as otherwise provided pursuant to subdivision (2) of this subdivision (a)(2)(H), an unemployed individual who is eligible for benefits pursuant to subdivisions (2)(A)(ii)–(vi) of this subsection shall be ineligible for benefits under those subdivisions if the individual becomes eligible for benefits provided pursuant to:

(I) enacted federal legislation that amends or establishes a federal program providing benefits for unemployed individuals that are similar to the benefits provided pursuant to subdivisions (2)(A)(ii)–(vi); or

(II) a national emergency declared by the President that results in the provision of benefits pursuant to Disaster Unemployment Assistance, Emergency Unemployment Compensation, Extended Unemployment Compensation, or any similar type program.

(ii) An individual who is receiving benefits pursuant to a federal program as set forth in subdivision (i) of this subdivision (a)(2)(H) shall not receive benefits pursuant to subdivisions (2)(A)(ii)–(vi) of this subsection except when and to the extent that the benefits provided by the applicable federal program are different from or are not in lieu of the benefits that are available pursuant to subdivisions (2)(A)(ii)–(vi) of this subsection, in which

case the benefits provided under subdivisions (2)(A)(ii)–(vi) of this subsection shall continue.

(iii) Nothing in this subdivision (a)(2)(H) shall be construed to prevent an individual from receiving benefits pursuant to subdivisions (2)(A)(ii)–(vi) of this subsection if the individual’s employer refuses or fails to pay the individual for leave under the federal Emergency Family and Medical Leave Expansion Act or the federal Emergency Paid Sick Leave Act.

\* \* \*

(5) For any week with respect to which the individual is receiving or has received remuneration in the form of:

\* \* \*

(F) Sick pay or pay received pursuant to the federal Emergency Family and Medical Leave Expansion Act or the federal Emergency Paid Sick Leave Act.

\* \* \*

\* \* \* Repeal of COVID-19 Related Unemployment Insurance

Provisions \* \* \*

Sec. 32. REPEAL

21 V.S.A. § 1325(a)(1)(G), (H), and (a)(3) are repealed.

Sec. 33. 21 V.S.A. § 1344 is amended to read:

§ 1344. DISQUALIFICATIONS

(a) An individual shall be disqualified for benefits:

\* \* \*

(2) For any week benefits are claimed, except as provided in subdivision (a)(3) of this section, until he or she has presented evidence to the satisfaction of the Commissioner that he or she has performed services in employment for a bona fide employer and has had earnings in excess of six times his or her weekly benefit amount if the Commissioner finds that such individual is unemployed because:

(A) He or she has left the employ of his or her last employing unit voluntarily without good cause attributable to such employing unit. An individual shall not suffer more than one disqualification by reason of such separation. However, an individual shall not be disqualified for benefits if:

(i) the individual left such employment to accompany a spouse who:

(i) is on active duty with the U.S. Armed Forces and is required to relocate due to permanent change of station orders, activation orders, or unit deployment orders, and when such relocation would make it impractical or impossible, as determined by the Commissioner, for the individual to continue working for such employing unit; or

(ii) holds a commission in the U.S. Foreign Service and is assigned overseas, and when such relocation would make it impractical or impossible, as determined by the Commissioner, for the individual to continue working for such employing unit;

~~(ii) the individual has left employment to self-isolate or quarantine at the recommendation of a healthcare provider, or pursuant to a specific recommendation, directive, or order issued by a public health authority with jurisdiction, the Governor, or the President for one of the following reasons:~~

~~(I) the individual has been diagnosed with COVID-19;~~

~~(II) the individual is experiencing the symptoms of COVID-19;~~

~~(III) the individual has been exposed to COVID-19; or~~

~~(IV) the individual belongs to a specific class or group of persons that have been identified as being at high risk if exposed to or infected with COVID-19;~~

~~(iii) the individual has left employment because of an unreasonable risk that the individual could be exposed to or become infected with COVID-19 at the individual's place of employment;~~

~~(iv) the individual has left employment to care for or assist a family member of the individual who is self-isolating or quarantining at the recommendation of a healthcare provider or pursuant to a specific recommendation, directive, or order issued by a public health authority with jurisdiction, the Governor, or the President, for one of the following reasons:~~

~~(I) the family member has been diagnosed with COVID-19;~~

~~(II) the family member is experiencing the symptoms of COVID-19;~~

~~(III) the family member has been exposed to COVID-19; or~~

~~(IV) the family member belongs to a specific class or group of persons that have been identified as being at high risk if exposed to or infected with COVID-19;~~

~~(v) the individual has left employment to care for or assist a family member who has left employment because of an unreasonable risk that they could be exposed to or become infected with COVID-19 at their place of employment; or~~

~~(vi) the individual left such employment to care for a child under 18 years of age because the child's school or child care has been closed or the child care provider is unavailable due to a public health emergency related to COVID-19.~~

~~(H)(i) Except as otherwise provided pursuant to subdivision (2) of this subdivision (a)(2)(H), an unemployed individual who is eligible for benefits pursuant to subdivisions (2)(A)(ii) (vi) of this subsection shall be ineligible for benefits under those subdivisions if the individual becomes eligible for benefits provided pursuant to:~~

~~(I) enacted federal legislation that amends or establishes a federal program providing benefits for unemployed individuals that are similar to the benefits provided pursuant to subdivisions (2)(A)(ii) (vi); or~~

~~(II) a national emergency declared by the President that results in the provision of benefits pursuant to Disaster Unemployment Assistance;~~

~~Emergency Unemployment Compensation, Extended Unemployment Compensation, or any similar type program.~~

~~(ii) An individual who is receiving benefits pursuant to a federal program as set forth in subdivision (i) of this subdivision (a)(2)(H) shall not receive benefits pursuant to subdivisions (2)(A)(ii)–(vi) of this subsection except when and to the extent that the benefits provided by the applicable federal program are different from or are not in lieu of the benefits that are available pursuant to subdivisions (2)(A)(ii)–(vi) of this subsection, in which case the benefits provided under subdivisions (2)(A)(ii)–(vi) of this subsection shall continue.~~

~~(iii) Nothing in this subdivision (a)(2)(H) shall be construed to prevent an individual from receiving benefits pursuant to subdivisions (2)(A)(ii)–(vi) of this subsection if the individual’s employer refuses or fails to pay the individual for leave under the federal Emergency Family and Medical Leave Expansion Act or the federal Emergency Paid Sick Leave Act.~~

\* \* \*

~~(G) As used in this subdivision (a)(2):~~

~~(i) “Family member” means an individual’s parent, grandparent, spouse, child, brother, sister, parent in law, grandchild, or foster child. As used in this subdivision (a)(2)(G)(i), “spouse” includes a domestic partner or civil union partner.~~

~~(ii) “An unreasonable risk that the individual could be exposed to or become infected with COVID-19 at the individual’s place of employment” shall include the individual’s place of employment being out of compliance with the Guidance on Preparing Workplaces for COVID-19 issued by the U.S. Occupational Safety and Health Administration (OSHA) or any similar guidance issued by OSHA, the U.S. Centers for Disease Control, or the Vermont Department of Health and any other conditions or factors that the Commissioner determines to create an unreasonable risk.~~

\* \* \*

(5) For any week in which the individual is receiving or has received remuneration in the form of:

\* \* \*

~~(F) Sick pay or pay received pursuant to the federal Emergency Family and Medical Leave Expansion Act or the federal Emergency Paid Sick Leave Act.~~

\* \* \*

Sec. 34. 21 V.S.A. § 1346 is amended to read:

§ 1346. CLAIMS FOR BENEFITS; RULES; NOTICE

\* \* \*

(c)(1) An employer shall post notice of how an unemployed individual can seek unemployment benefits in a form provided by the Commissioner in a place conspicuous to individuals performing services for the employer. The



notice shall also advise individuals of their rights under the Domestic and Sexual Violence Survivor's Transitional Employment Program, established pursuant to chapter 16A of this title. The Commissioner shall provide a copy of the notice to an employer upon request without cost to the employer.

(2) An employer shall provide an individual with notification of the availability of unemployment compensation at the time of the individual's separation from employment. The notification may be based on model notification language provided by the U.S. Secretary of Labor.

\* \* \* Motor Vehicles \* \* \*

#### Sec. 35. PHOTOGRAPHS FOR RENEWALS

(a) Notwithstanding any provision of 23 V.S.A. § 115(g), 610(c), or 617(e) to the contrary, a licensee shall be permitted to renew a driver's license, learner's permit, privilege to operate, or non-driver identification card with a photograph obtained not more than 16 years earlier that is compliant with the federal REAL ID Act, 6 C.F.R. part 37.

(b) Notwithstanding 1 V.S.A. § 214, subsection (a) of this section shall take effect retroactively on March 20, 2020 and continue in effect until the termination of the state of emergency declared by the Governor as a result of COVID-19.

#### Sec. 36. EXTENSIONS

(a) Notwithstanding any provision of 23 V.S.A. § 312, 457, 458, 3702, or 3703 to the contrary, all International Registration Plan trip permits and

temporary authorizations, temporary registration certificates, and temporary number plates shall be valid for 90 days from the date of issuance.

(b) Notwithstanding any provision of Title 23 of the Vermont Statutes Annotated or rules adopted pursuant to Title 23 to the contrary, the Commissioner of Motor Vehicles may extend any existing permits issued by the Department of Motor Vehicles, excluding International Registration Plan trip permits, for an additional 90 days.

(c) Notwithstanding any provision of 23 V.S.A. § 115, 302, 304a, 305, 601, or 617 to the contrary, the Commissioner shall extend all of the following for an additional 90 days after expiration: driver's licenses; learner's permits; privileges to operate; non-driver identification cards; registrations; and registration plates or placards for an individual with a disability.

(d) Notwithstanding 1 V.S.A. § 214, subsections (a) and (b) of this section shall take effect retroactively on March 20, 2020 and continue in effect until the termination of the state of emergency declared by the Governor as a result of COVID-19.

(e) Notwithstanding 1 V.S.A. § 214, subsection (c) of this section shall take effect retroactively on March 17, 2020 and continue in effect until the termination of the state of emergency declared by the Governor as a result of COVID-19.

Sec. 37. USE OF EIGHT-LIGHT SYSTEM ON SCHOOL BUSES

(a) Notwithstanding any provision of 23 V.S.A. § 1283(a)(4) to the contrary, the driver of a Type I or a Type II school bus may keep the alternately flashing red signal lamps of an eight-light system lighted when making deliveries of food to school aged children.

(b) Notwithstanding 1 V.S.A. § 214, subsection (a) of this section shall take effect retroactively on March 20, 2020 and continue in effect until the termination of the state of emergency declared by the Governor as a result of COVID-19.

\* \* \* Effective Dates \* \* \*

Sec. 38. EFFECTIVE DATES

This act shall take effect on passage, except that:

(1) In Sec. 24, 8 V.S.A. § 4100k(e) (coverage of health care services delivered by store-and-forward means) shall take effect on January 1, 2021.

(2) Sec. 29 shall take effect on July 1, 2020.

(3) Secs. 32 and 33 shall take effect on March 31, 2021.

Date Governor signed bill: March 30, 2020