EMERGENCY RULE # 22-E10

# Emergency Filing - Coversheet

**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 shall be submitted to 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*). A staffing crisis in Vermont nursing homes threatens to harm care for vulnerable Vermonters.

I approve the contents of this filing entitled:

Nursing Home Rate Setting Staffing Adjustment

*/s/ Todd W. Daloz* , on *4/27/22*

(signature) (date)

Printed Name and Title:

Todd W. Daloz

Deputy Secretary, Agency of Human Services

RECEIVED BY: _____

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

1. TITLE OF RULE FILING:
   Nursing Home Rate Setting Staffing Adjustment
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: James LaRock, Staff Attorney

   Agency: Department of Vermont Health Access

   Mailing Address: 280 State Drive, Waterbury, VT 05676

   Telephone: 802 904 - 3188 Fax: -

   E-Mail: james.larock@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, Division of Rate Setting

   Agency: Department of Vermont Health Access

   Mailing Address: 280 State Drive, Waterbury, VT 05676

   Telephone: 802 398 - 5282 Fax: -

   E-Mail: lindsay.gillette@vermont.gov
5. RECORDS EXEMPTION INCLUDED WITHIN RULE:
   *(DOES THE RULE CONTAIN ANY PROVISION DESIGNATING INFORMATION AS CONFIDENTIAL; LIMITING ITS PUBLIC RELEASE; OR OTHERWISE EXEMPTING IT FROM INSPECTION AND COPYING*?) Yes

   IF YES, CITE THE STATUTORY AUTHORITY FOR THE EXEMPTION:

   1 V.S.A. § 317(c), 33 V.S.A. § 908(a), 45 C.F.R. Parts 160, 162, 164

   PLEASE SUMMARIZE THE REASON FOR THE EXEMPTION:

   The exemption is in the existing DRS rules that these emergency rules modify at § 2.5(d). DRS withholds all individually identifiable health information protected

by law or by the policies, practices, and procedures of the Agency of Human Services (AHS), and does not make the salaries and wages of individual nursing home employees public.

6. LEGAL AUTHORITY / ENABLING LEGISLATION:
*(THE SPECIFIC STATUTORY OR LEGAL CITATION FROM SESSION LAW INDICATING WHO THE ADOPTING ENTITY IS AND THUS WHO THE SIGNATORY SHOULD BE. THIS SHOULD BE A SPECIFIC CITATION NOT A CHAPTER CITATION).*
This rule is issued pursuant to the authority vested in AHS by 33 V.S.A. § 908(c), 33 V.S.A. § 1901(a)(1), Act 85 of 2022 (H.654), and in response to Act 83 of 2022 (H.679), § 46.

7. EXPLANATION OF HOW THE RULE IS WITHIN THE AUTHORITY OF THE AGENCY:
The emergency rule is within the Secretary of AHS's authority to make rules required to implement the statutory requirements for nursing home rate setting and to administer the Medicaid program. 33 V.S.A. §§ 908(c) and 1901(a)(1). Act 85 of 2022 directs AHS, which contains DVHA, to consider modifying existing rules or adopting emergency rules to protect access to health care and long-term care services. Act 83 of 2022 directs AHS to "address costs associated with staffing for nursing homes." The rule is necessary to address costs associated with staffing for nursing homes and to protect access to long-term care services.

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

This emergency rule addresses costs at nursing homes associated with increased nursing staffing costs by increasing the existing inflation factor in the Division of Rate Setting's rules to account for the increased inflation in nursing care costs since the beginning of state fiscal year 2022.

9. EXPLANATION OF WHY THE RULE IS NECESSARY:

The emergency rule is necessary to ensure that nursing homes are adequately reimbursed for the cost of providing nursing care during a severe, prolonged spike in the cost of delivering nursing care.

The Division's rules currently provide two different avenues for granting financial relief to nursing homes,

but neither is able to provide nursing homes appropriate financial relief. First, the Division's existing emergency financial relief process requires a nursing home to be in immediate danger of failure before the facility can receive relief. (V.D.R.S.R. § 10). Once a facility is in immediate danger of failure, the facility is often incurring related costs, such as debt servicing costs or penalties for nonpayment on contracts, that exacerbate their financial situation. It is far preferable to provide targeted relief to a nursing home before it enters that situation. Second, the Division's existing rate adjustment rules have strict requirements. (V.D.R.S.R. § 8). To enforce those requirements, the Division's auditors must exhaustively review all rate adjustment applications, taking significant staff time that the Division's current staff of 4 auditors cannot spare in addition to their normal duties. In order to comply with Act 83 of 2022, the Division needs to develop an alternative means of quickly, but fairly, adjusting the nursing care cost component of the Medicaid rates at each facility as appropriate to account for increased nursing costs.

To that end, the Division proposes adjusting the inflation factor that it uses to modify Medicaid rates to account for the increased inflation in the sector since the beginning of state fiscal year 2022. Specifically, as part of the normal rate setting process, the Division adjusts each major component of the Medicaid rate according to specific price indices. (V.D.R.S.R. § 5.8). On July 1, 2021, the price index the Division uses to inflate the nursing care cost component estimated that nursing care costs had risen by 9.65% since the data that the Division uses to calculcate that component of the Medicaid rate had been collected. However, since July 1, nursing care costs continued to increase at a rate far outstripping that inflation factor. After reviewing data from almost all nursing homes in Vermont, the Division now estimates that nursing care costs have increased by an additional 9.18% over what the Division's price index predicted.

10. EXPLANATION OF HOW THE RULE IS NOT ARBITRARY AS DEFINED IN 3 V.S.A. § 801(b)(13(A):

The Division worked extensively with affected nursing homes and their advocates to gather and verify information about the increase in nursing care costs in Vermont over the past calendar year to ensure that there is a factual basis for this action. Adjusting the inflation factor for nursing care costs is the most practical way for the Division to quickly and fairly provide relief across the nursing home sector.

Alternatives to this decision, such as encouraging facilities to use the Division's existing rate adjustment and emergency financial relief process, would be administratively impossible with the Division's current staffing limitations. Were the Division to attempt to process rate adjustment requests or emergency financial relief requests for each affected facility, the Division would need outside assistance from consultants or contractors, who would also require additional supervision; this would quickly make the process significantly more expensive, limiting the potential availability of funds for affected nursing homes. Requiring providers to file rate adjustment or emergency financial relief requests would also increase the burden on providers who are already struggling with the increase in nursing care costs.

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

The rule affects the the Agency of Human Services and two of its constituent departments: DVHA and the Department of Disabilities, Aging, and Independent Living. The rule also affects all nursing homes that accept Vermont Medicaid for payment.

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

The rule will provide financial support to nursing homes to alleviate the impact of increased nursing costs in the wake of the COVID-19 pandemic.

13. A HEARING IS NOT SCHEDULED .

14. HEARING INFORMATION

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

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

Date:

Time: AM

Street Address:

Zip Code:

Date:

Time: AM

Street Address:

Zip Code:

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

16. EMERGENCY RULE EFFECTIVE: 05/01/2022

17. EMERGENCY RULE WILL REMAIN IN EFFECT UNTIL
*(A DATE NO LATER THAN 180 DAYS FOLLOWING ADOPTION OF THIS EMERGENCY RULE)*:
09/01/2022

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

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

Nursing home

Medicaid

Staffing

Travel nurses

# 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.

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1. TITLE OF RULE FILING:
   Nursing Home Rate Setting Staffing Adjustment
2. ADOPTING AGENCY:
   Department of Vermont Health Access (DVHA), Division of Rate Setting (DRS)
3. TYPE OF FILING (*PLEASE CHOOSE THE TYPE OF FILING FROM THE DROPDOWN MENU BASED ON THE DEFINITIONS PROVIDED BELOW*):

   - **AMENDMENT** - Any change to an already existing rule, even if it is a complete rewrite of the rule, it is considered an amendment as long as the rule is replaced with other text.
   - **NEW RULE** - A rule that did not previously exist even under a different name.
   - **REPEAL** - The removal of a rule in its entirety, without replacing it with other text.

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

4. LAST ADOPTED (*PLEASE PROVIDE THE SOS LOG#, TITLE AND EFFECTIVE DATE OF THE LAST ADOPTION FOR THE EXISTING RULE*):
   SOS log# 15-002

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

Effective March 6, 2015

VERMONT

**State of Vermont**
**Agency of Administration**
**Office of the Secretary**
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109 State Street, 5th Floor
Montpelier, VT 05609-0201
www.aoa.vermont.gov

[phone] 802-828-3322
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*Kristin L. Clouser, Secretary*

**MEMORANDUM**

**TO:** **Jim Condos, Secretary of State**
**FROM:** **Douglas Farnham, ICAR Chair** Douglas Farnham Digitally signed by Douglas Farnham Date: 2022.04.27 11:39:44 -04'00'
**DATE:** **April 27, 2022**
**RE:** **Emergency Rule Titled 'Nursing Home Rate Setting Staffing Adjustment' by the Agency of Human Services, Department of Vermont Health Access**

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 titled 'Nursing Home Rate Setting Staffing Adjustment', provided by the Department of Vermont Health Access, and agree that emergency rulemaking is necessary.

###

VERMONT

# 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. If no impacts are anticipated, please specify "No impact anticipated" in the field.

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.

1. TITLE OF RULE FILING:

   Nursing Home Rate Setting Staffing Adjustment

2. ADOPTING AGENCY:

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

3. CATEGORY OF AFFECTED PARTIES:

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

   Privately owned nursing facilities providing services to Vermont Medicaid residents.

4. IMPACT ON SCHOOLS:

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

None anticipated.

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

   N/A because no impact is anticipated.

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 alleviate increased staffing costs incurred by all privately owned nursing homes that accept Vermont Medicaid as payment, some of which may be small businesses.

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.*

   There will be no burden of compliance on small businesses. All nursing homes will see an increase in their reimbursement to account for the increase in nursing care costs automatically, subject to existing caps on rates, without the need for any filing.

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:*
   There will be no burden of compliance on small business and most should see a positive economic impact. Passing no rule on the subject would leave the status quo in place, including the current burdens of increasing nursing care costs and the administrative burden of filing rate adjustment requests and emergency financial relief requests.

9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*

Vermont nursing homes provided information to the Division regarding how much they had spent on staff nursing costs and travel nursing costs over the past calendar year. The Division received this information from all but five Vermont nursing homes that take Medicaid patients and reasonably extrapolated from the other data to infer how much nursing care costs increased at those five facilities. The Division then analyzed those costs in light of the pre-existing inflation adjustment to determine how much nursing care costs have increased over and above the pre-existing inflation adjustment. The Division further consulted external price indices that account for nursing care costs to determine current estimates for the inflation in nursing care costs regionally and nationwide. Finally, the Division determined how much of the increased cost can be allocated to Medicaid patients, because only care delivered to Medicaid patients can be reimbursed using Medicaid dollars in order to receive federal matching funds. In light of the urgency of responding to this financial crisis, the analysis here is sufficient to enact the emergency rule.

# 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. If no impacts are anticipated, please specify "No impact anticipated" in the field.

Examples of Environmental Impacts include but are not limited to:

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

1. TITLE OF RULE FILING:

   Nursing Home Rate Setting Staffing Adjustment

2. ADOPTING AGENCY:

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

3. GREENHOUSE GAS: *EXPLAIN HOW THE RULE IMPACTS THE EMISSION OF GREENHOUSE GASES (E.G. TRANSPORTATION OF PEOPLE OR GOODS; BUILDING INFRASTRUCTURE; LAND USE AND DEVELOPMENT, WASTE GENERATION, ETC.):*
   None anticipated.

4. WATER: *EXPLAIN HOW THE RULE IMPACTS WATER (E.G. DISCHARGE / ELIMINATION OF POLLUTION INTO VERMONT WATERS, THE FLOW OF WATER IN THE STATE, WATER QUALITY ETC.):*
   None anticipated.

5. LAND: *EXPLAIN HOW THE RULE IMPACTS LAND (E.G. IMPACTS ON FORESTRY, AGRICULTURE ETC.):*
   None anticipated.

6. RECREATION: *EXPLAIN HOW THE RULE IMPACT RECREATION IN THE STATE:*
   None anticipated.

7. CLIMATE: *EXPLAIN HOW THE RULE IMPACTS THE CLIMATE IN THE STATE:*
   None anticipated.

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

9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
   The rule is not anticipated to have any environmental impact.

# Public Input Maximization Plan

**Instructions:**

Agencies are encouraged to hold hearings as part of their strategy to maximize the involvement of the public in the development of rules. Please complete the form below by describing the agency's strategy for maximizing public input (what it did do, or will do to maximize the involvement of the public).

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

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1. TITLE OF RULE FILING:

   Nursing Home Rate Setting Staffing Adjustment

2. ADOPTING AGENCY:

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

3. PLEASE DESCRIBE THE AGENCY'S STRATEGY TO MAXIMIZE PUBLIC INVOLVEMENT IN THE DEVELOPMENT OF THE PROPOSED RULE, LISTING THE STEPS THAT HAVE BEEN OR WILL BE TAKEN TO COMPLY WITH THAT STRATEGY:

   N/A. This rule is a temporary measure to support nursing homes that have incurred unexpectedly increased costs until July 1, 2023, when nursing home costs will be fully rebased at 2021 levels, plus an inflation factor. DVHA will not develop a regular rule.

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

   DRS has contacted the trade association for Vermont nursing homes to investigate how the staffing crisis has impacted each nursing home, exchange proposals for fairly reimbursing the nursing homes for the costs they have incurred, and receive comments.

280 State Drive – Center Building
Waterbury, VT 05671-1000

OFFICE OF THE SECRETARY
TEL: (802) 241-0440
FAX: (802) 241-0450

JENNEY SAMUELSON
SECRETARY

TODD W. DALOZ
DEPUTY SECRETARY

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

# MEMORANDUM

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

**FROM:** Jenney Samuelson, Secretary, Agency of Human Services

**DATE:** April 1, 2022

**SUBJECT:** Signatory Authority for Purposes of Authorizing Administrative Rules

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I hereby designate Deputy Secretary of Human Services Todd W. Daloz as signatory to fulfill the duties of the Secretary of the Agency of Human Services as the adopting authority for administrative rules as required by Vermont's Administrative Procedure Act, 3 V.S.A. § 801 et seq.

Cc: Todd W. Daloz

Annotated Text

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

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

~~**MARCH 2015**~~

**Emergency Rule**
**May 2022**
{Additions to the existing rule are underlined and removals ~~stricken~~.}

# TABLE OF CONTENTS

Cite as Vermont Division of Rate Setting Rules (V.D.R.S.R.)

# 1 GENERAL PROVISIONS

## 1.1 Purpose

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

## 1.2 Scope

These rules apply to all privately owned nursing facilities and state nursing facilities providing services to Medicaid residents. Long-term care services in swing-bed hospitals, and Intermediate Care Facilities for the Mentally Retarded are reimbursed under different methods and standards. Swing-bed hospitals are reimbursed pursuant to 42 U.S.C. §1396l(b)(1). Intermediate Care Facilities for the Mentally Retarded are reimbursed pursuant to the *Regulations Governing the Operation of Intermediate Care Facilities for the Mentally Retarded* adopted by the Agency and are subject to the Division's Accounting Requirements (Section 2) and Financial Reporting (Section 3).

## 1.3 Authority

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

## 1.4 General Description of the Rate Setting System

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

## 1.5 Requirements for Participation in Medicaid Program

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

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

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

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

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

(c) Medicaid payments shall not be made to any facility that fails to meet all the requirements of Subsection 1.5(a).

### 1.6 Responsibilities of Owners

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

### 1.7 Duties of the Owner

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

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

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

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

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

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

(f) Notwithstanding any other provision of these rules, any provider that fails to make a complete cost report filing within the time prescribed in subsection 3.3(a) or fails to file any other materials requested by the Division within the time prescribed shall receive no increase to its Medicaid rate until the first day of the calendar quarter after a complete cost report or the requested materials are filed, unless within an extension of time previously approved by the Division.

### 1.8 Powers and Duties of the Division and the Director

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

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

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

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

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

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

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

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

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

(a) The Division of Licensing and Protection of the Department of Disabilities, Aging and Independent Living shall receive from providers resident assessments on forms it specifies. The Department of Disabilities, Aging and Independent Living shall process this information and shall periodically, but no less frequently than quarterly, provide the Division of Rate Setting with the average case-mix scores of each facility based upon the federal RUG IV classification system (48 group version). This score will be used in the quarterly determination of the Nursing Care portion of the rate.

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

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

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

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

(c) When by these rules or by a notice given thereunder, an act is required or allowed to be done at or within a specified time, the relevant administrative officer, for just cause shown, may at any time in her or his discretion, with or without motion or notice, order the period enlarged. This subsection shall not apply to the time limits for appeals to the Vermont Supreme Court or Superior Court from Final Orders of the Division or Final Determinations of the Secretary, which are governed by the Vermont Rules of Appellate Procedure and the Vermont Rules of Civil Procedure respectively.

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

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

### 1.11 Representation in All Matters before the Division

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

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

### 1.12 Severability

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

### 1.13 Effective Date

(a) These rules are effective from January 29, 1992, (as amended June 18, 1993, July 1, 1994, January 4, 1995, January 1, 1996, January 1, 1997, July 1, 1998, May 1, 1999, July 1, 1999, August 1, 1999, July 1, 2001, November 1, 2002, May 1, 2004, July 1, 2004, July 1, 2005, October 29, 2007, August 25, 2008, April 1, 2011, September 17, 2012, September 9, 2013, and March 6, 2015).

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

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

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

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

## 2 ACCOUNTING REQUIREMENTS

### 2.1 Accounting Principles

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

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

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

The provider shall retain all such documentation for audit purposes.

**2.2 Procurement Standards**

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

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

**2.3 Cost Allocation Plans and Changes in Accounting Principles**

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

(a) [Repealed]

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

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

(d) [Repealed]

(e) [Repealed]

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

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

(1) Nursing salaries and supplies - direct cost,

(2) Plant operations - square footage,

(3) Utilities - square footage,

(4) Laundry - pounds of laundry,

(5) Dietary -resident days,

(6) Administrative and General - accumulated costs,

(7) [Repealed]

(8) Property and Related - square footage,

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

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

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

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

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

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

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

### 2.4 Substance Over Form

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

### 2.5 Record Keeping and Retention of Records

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

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

(c) The provider shall maintain all such records for at least six years from the date of filing, or the date upon which the fiscal and statistical records were to be filed, whichever is the later. The Division shall keep all cost reports, supporting documentation submitted by the provider, correspondence, workpapers and other analyses supporting Summaries of Findings for six years. In the event of litigation or appeal involving rates established under these regulations, the provider and Division shall retain all records which are in any way related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.

(d) Pursuant to 33 V.S.A. §908(a), all documents and other materials filed with the Division are public information, except for individually identifiable health information protected by law or the policies, practices, and procedures of the Agency of Human Services. With the exception of the administrator's salary, the salaries and wages of individual employees shall not be made public.

## 3 FINANCIAL REPORTING

### 3.1 [Repealed]

### 3.2 Uniform Cost Reports

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

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

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

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

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

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

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

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

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

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

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

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

### 3.3 Adequacy and Timeliness of Filing

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

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

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

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

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

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

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

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

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

### 3.4 Review of Cost Reports by Division

(a) Uniform Desk Review

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

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

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

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

(b) On-site Audit

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

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

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

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

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

### 3.5 Settlement of Cost Reports

(a) A cost report is settled if there is no request for reconsideration of the Division's findings or, if such request was made, the

Division has issued a final order pursuant to Subsection 15.3 of these rules.

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

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

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

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

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

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

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

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

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

## 4 DETERMINATION OF ALLOWABLE COSTS FOR NURSING FACILITIES

### 4.1 Provider Reimbursement Manual and GAAP

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

### 4.2 General Cost Principles

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

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

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

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

### 4.3 Non-Recurring Costs

(a) Non-recurring costs shall include:

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

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

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

(b) A non-recurring cost shall be capitalized and amortized and carried as an on-going adjustment beginning with the first quarterly rate change after the settlement of the cost report for a period of three years.

### 4.4 Interest Expense

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

(b) "Necessary requires that:

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

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

(3) Cash and cash equivalents include:

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

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

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

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

(4) Cash and cash equivalents exclude:

(i) funded depreciation recognized by the Division,

(ii) restricted grants and gifts.

(5) Interest income offset.

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

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

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

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

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

(c) "Proper" requires that:

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

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

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

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

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

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

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

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

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

Equals: The limits on borrowings related to fixed assets.

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

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

(i) Application of Principal Payments.

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

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

(j) Refinancing of indebtedness.

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

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

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

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

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

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

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

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

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

### 4.5 Basis of Property, Plant and Equipment

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

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

(1) purchase price,

(2) sales tax,

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

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

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

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

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

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

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

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

**4.6 Depreciation and Amortization of Property, Plant and Equipment**

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

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

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

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

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

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

**4.7 Change in Ownership of Depreciable Assets - Sales of Facilities**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) the fair market value of the assets,

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

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

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

(i) the fair market value of the assets,

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

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

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

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

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

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

**4.8 [Repealed]**

**4.9 Leasing Arrangements for Property, Plant and Equipment**

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

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

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

**4.10 Funding of Depreciation**

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

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

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

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

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

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

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

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

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

**4.11 Adjustments for Large Asset Acquisitions and Changes of Ownership**

(a) Large Asset Acquisitions

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

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

(b) Changes of Ownership

(1) Application shall also be made under this subsection, no later than 30 days after the execution of a purchase and sale agreement or other binding contract, or the receipt of a Certificate of Need pursuant to 18 V.S.A. §9434, for changes in basis resulting from a change in ownership of depreciable assets recognized by the Division pursuant to Subsection 4.7. The Division may make related adjustments to the Property and Related rate component.

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

(c) Except in circumstances determined by the Division to constitute an emergency precluding a 60 day notice period, a provider applying for an adjustment pursuant to this subsection is required to give 60 days written notice to the Division prior to the purchase of the asset. Such applications shall be exempt from the materiality test set out in subsection 8.7(b), but are subject to the other provisions of subsection 8.7. The burden is on the provider to document all information applicable to this adjustment and to demonstrate that any costs to be incurred are necessary and reasonable. When applicable, such documentation shall include the Certificate of Need application and all supporting financial information. The Division shall review the application and issue draft findings approving, denying, or proposing modifications to the adjustment applied for within 60 days of receipt of all information required.

**4.12 [Repealed]**

**4.13 Advertising Expenses**

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

**4.14 Barber and Beauty Service Costs**

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

**4.15 Bad Debt, Charity and Courtesy Allowances**

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

**4.16 Child Day Care**

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

**4.17 Community Service Activities**

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

**4.18 Dental Services**

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

**4.19 Legal Costs**

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

**4.20 Litigation and Settlement Costs**

(a) Civil and criminal litigation -

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

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

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

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

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

**4.21 Motor Vehicle Allowance**

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

**4.22 Non-Competition Agreement Costs**

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

**4.23 Compensation of Owners, Operators, or their Relatives**

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

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

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

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

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

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

**4.24 Management Fees and Home Office Costs**

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

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

**4.25 Membership Dues**

Reasonable and necessary membership dues, including any portions used for lobbying

activities, shall be considered Medicaid allowable costs, provided the organization's function and purpose are directly related to providing resident care.

**4.26 Post-Retirement Benefits**

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

**4.27 Public Relations**

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

**4.28 Related Party**

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

**4.29 Revenues**

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

**4.30 Travel/Entertainment Costs**

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

**4.31 Transportation Costs**

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

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

**4.32 Services Directly Billable**

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

## 5 REIMBURSEMENT STANDARDS

**5.1 Prospective Case-Mix Reimbursement System**

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

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

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

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

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

(c) Per diem rates shall be prospectively determined for the rate year based on the allowable operating costs of a facility in a Base Year, plus property and related and ancillary costs from the most recently settled cost report, calculated as described in Subsection 9.2.

### 5.2 Retroactive Adjustments to Prospective Rates

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

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

(1) as an adjustment pursuant to Sections 8 and 10;

(2) in response to a decision by the Secretary pursuant to Subsection 15.5 or to an order of a court of competent jurisdiction, whether or not that order is the result of a decision on the merits, or as the result of a settlement pursuant to Subsection 15.8;

(3) for mechanical computation or typographical errors;

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

(5) as a result of revised findings resulting from the reopening of a settled cost report pursuant to Subsection 3.5;

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

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

(8) when a special rate is revised pursuant to subsection 14.1(e)(2) or

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

### 5.3 Lower of Rate or Charges

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

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

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

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

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

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

### 5.4 Interim Rates

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

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

### 5.5 Upper Payment Limits

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

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

### 5.6 Base Year

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

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

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

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

### 5.7 Occupancy Level

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

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

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

(d) Decreasing the Number of Licensed Beds – For any facility that operated at less than 90 percent occupancy during the period used as the cost basis for any rate component subject

to subsection (b) which subsequently reduces the number of licensed beds, the minimum occupancy shall be calculated based on the number of the facility's licensed beds on the first day of the quarter after the facility notifies the Division of such reduction.

### 5.8 Inflation Factors

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

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

For the four rate quarters beginning July 1, 2021, October 1, 2021, January 1, 2022, and April 1, 2022, the Nursing Care rate component shall be increased by an additional 9.18% to account for sustained increases in the rate component.

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

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

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

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

### 5.9 Costs for New Facilities

(a) For facilities that are newly constructed, newly operated as nursing facilities, or new to the Medicaid program, the prospective case-mix rate shall be determined based on budget cost reports submitted to the Division and the greater of the estimated resident days for the rate year or the resident days equal to 90 percent occupancy of all beds used or intended to be used for resident care at any time within the budget cost reporting period. This rate shall remain in effect no longer than one year from the effective date of the new rate. The principles on allowability of costs and existing limits in Sections 4 and 7 shall apply.

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

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

(d) At the end of the first year of operation, the prospective case-mix rate shall be revised based on the provider's actual allowable costs as reported in its annual cost report filed pursuant to subsection 3.2 for its first full fiscal year of operation.

### 5.10 Costs for Terminating Facilities

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

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

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

(d) In approving such an application the Division may waive the minimum occupancy requirements in Subsection 5.7, the limitations on costs in Section 7, or make such other reasonable adjustments to the facility's reimbursement rate as shall be appropriate in the circumstances. The adjustments made under this subsection shall remain in effect for a period not to exceed six months.

## 6 BASE YEAR COST CATEGORIES FOR NURSING FACILITIES

### 6.1 General

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

### 6.2 Nursing Care Costs

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

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

(b) Costs of bedmakers, geriatric aides, transportation aides, paid feeding/dining assistants, ward clerks, medical records

librarians and other unlicensed staff will not be considered nursing costs. The salary and related benefits of the position of Director of Nursing shall be excluded from the calculation of allowable nursing costs and shall be reimbursed separately.

### 6.3 Resident Care Costs

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

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

### 6.4 Indirect Costs

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

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

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

### 6.5 Director of Nursing

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

### 6.6 Property and Related

(a) The following are Property and Related costs:

(1) depreciation on buildings and fixed equipment, major movable equipment, minor equipment, computers, motor vehicle, land improvements, and amortization of leasehold improvements and capital leases,
(2) interest on capital indebtedness,
(3) real estate leases and rents,
(4) real estate/property taxes,
(5) all equipment irrespective of whether it is capitalized, expensed, or rented,
(6) fire and casualty insurance,
(7) amortization of mortgage acquisition costs.

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

### 6.7 Ancillaries

(a) The following are ancillary costs:

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

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

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

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

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

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

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

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

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

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

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

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

(b) [Repealed]

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

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

### 7.1 Calculation of Per Diem Costs

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

### 7.2 Nursing Care Component

(a) Case-Mix Weights.

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

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

(b) Average case-mix score

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

(1) The Division of Licensing and Protection shall periodically, but no less

frequently than quarterly, certify to the Division of Rate Setting the average case-mix score for those residents of each facility whose room and board (excluding resident share) is paid for solely by the Medicaid program.

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

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

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

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

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

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

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

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

### 7.3 Resident Care Base Year Rate

Resident Care Base Year rates shall be computed as follows:

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

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

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

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

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

### 7.4 Indirect Base Year Rate

Indirect Base Year rates shall be computed as follows:

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

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

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

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

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

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

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

### 7.5 Director of Nursing Base Year Rate

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

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

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

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

### 7.6 Ancillary Services Rate

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

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

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

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

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

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

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

### 7.7 Property and Related Per Diem

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

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

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

case-mix rate recalculation after the cost report is settled.

### 7.8 Limits Final

Once a final order has been issued for all facilities' Base Year cost reports, notwithstanding any subsequent changes to the cost report findings, resulting from a reopening, appeal, or other reason, the limits set pursuant to subsections 7.2(d)(2), 7.3(d), and 7.4(d) will not change until nursing home costs are rebased pursuant to 5.6(b), except for annual adjustment by the inflation factors or a change in law necessitating such a change.

## 8 ADJUSTMENTS TO RATES

### 8.1 Change in Services

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

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

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

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

### 8.2 Change in Law

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

### 8.3 Facilities in Receivership

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

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

### 8.4 Efficiency Measures

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

### 8.5 Interest Rates

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

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

### 8.6 Emergencies and Unforeseeable Circumstances

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

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

### 8.7 Procedures and Requirements for Rate Adjustments

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

(b) Except for applications made pursuant to subsection 4.11, no application for a rate adjustment should be made if the change to the rate would be smaller than one percent of the rate in effect at the time.

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

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

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

(f) The Division shall not be bound in considering other Applications, or in determining the allowability of reported costs, by any prior decision made on any Application under this section. Such decisions shall have no precedential value either for the applicant facility or for any other facility. Principles and decisions of general applicability shall be issued as a Division practice or procedure, pursuant to Section 1.8(d).

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

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

(i) The Division may require an applicant for a rate adjustment under this section or under subsection 4.11 to file a budget cost report in support of its application.

(j) When determined to be appropriate by the Division, a budget rate may be set for the facility according to the procedures in and subject to the provisions of subsection 5.9. Appropriate cases may include, but are not limited to, changes in the number of beds, an addition to the facility, or the replacement of existing property.

(k) In calculating an adjustment under this section and subsection 4.11, the Division may take into account the effect of such

changes on all the cost categories of the facility.

(l) A revision may be made prospectively to a rate adjustment under this section and subsection 4.11 based on a "look-back" which will be computed based on a provider's actual allowable costs.

(m) In this subsection "additional costs" means the incremental costs of providing resident care directly and proximately caused by one of the events listed in this section or subsection 4.11. Increases in costs resulting from other causes will not be recognized. It is not intended that this section be used to effect a general rebase in a facility's costs.

### 8.8 Limitation on Availability of Rate Adjustments

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

## 9 PRIVATE NURSING FACILITY AND STATE NURSING FACILITY RATES

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

### 9.1 Nursing Facility Rate Components

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

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

### 9.2 Calculation of the Total Rate

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

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

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

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

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

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

### 9.4 State Nursing Facilities

(a) Notwithstanding any other provisions of these rules, payment rates for state nursing facilities shall be determined retrospectively by the Division based on the reasonable and necessary costs of providing those services as determined using the cost reporting and cost finding principles set out in sections 3 and 4 of these rules.

(b) Until such time as the cost report is settled, the Division shall set an interim rate

based on an estimate of the facility's costs and census for the rate year.

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

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

**9.5 Quality Incentives**

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

(a) These payments will be based on:

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

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

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

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

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

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

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

(e) Award Criteria

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

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

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

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

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

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

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

## 10 EXTRAORDINARY FINANCIAL RELIEF

### 10.1 Objective

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

### 10.2 Nature of the Relief

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

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

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

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

### 10.3 Criteria to be Considered by the Division

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

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

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

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

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

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

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

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

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

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

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

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

(11) the age and condition of the facility,

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

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

**10.4 Procedure for Application**

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

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

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

## 11 PAYMENT FOR OUT-OF-STATE PROVIDERS

**11.1 Long-Term Care Facilities Other Than Rehabilitation Centers**

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

**11.2 Rehabilitation Centers**

(a) Payment for prior-authorized Rehabilitation Center services provided in nursing facilities located outside Vermont for the severely disabled, such as head injured or ventilator dependent people, will be made at the lowest of:

(1) the amount charged; or

(2) the Medicaid rate, including ancillaries as paid by at least one other state agency in CMS Region I.

(b) Payment for Rehabilitation Center services which have not been prior authorized by the Commissioner of the Department of Vermont Health Access or a designee will be made according to Subsection 11.1.

**11.3 Pediatric Care**

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

## 12 RATES FOR ICF/MRS

**12.1 Reasonable Cost Reimbursement**

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

**12.2 Application of these Rules to ICF/MRS**

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

## 13 RATES FOR SWING BEDS AND OTHER LONG-TERM CARE SERVICES IN HOSPITALS

Payment for swing-bed and other long-term care services provided by hospitals, pursuant to 42 U.S.C. §1396l(a), shall be made at a rate equal to the average rate per diem during the previous calendar year under the State Plan to nursing facilities located in the State of Vermont. Supplemental payments made pursuant to section 14 and subsection 9.5 shall not be included in the calculation of swing-bed rates.

## 14 SPECIAL RATES FOR CERTAIN INDIVIDUAL RESIDENTS

### 14.1 Availability of Special Rates for Individuals with Unique Physical Conditions

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

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

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

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

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

(d) Plan of Care:

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

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

(e) Calculation of the Special Rate:

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

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

(3) Special rates set under this section shall not affect the facility's normal per diem rate. The case-mix weight of any resident on whose behalf a special rate is paid shall not be included in the calculation of the facility's average case-mix score pursuant to subsection 7.2(b), but the days of care shall be included in the facility's Medicaid

days and total resident days. The provider shall track the total costs of providing care to the resident and shall self-disallow the incremental cost of such care on cost reports covering the period during which the facility receives Medicaid payments for services to the resident.

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

(a) A special rate is available for nursing home services to patients transferred directly from the Vermont State Hospital or to such other similarly situated individuals as the Commissioner of Mental Health shall approve. The rate shall be prospective and shall be set before admission of the individual to the facility.

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

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

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

(c) Criteria for continuation of supplemental payments:

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

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

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

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

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

## 15 ADMINISTRATIVE REVIEW AND APPEALS

### 15.1 Draft Findings and Decisions

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

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

### 15.2 Request for an Informal Conference on Draft Findings and Decisions

(a) Within 15 days of receipt of either the draft findings or decision or requested work papers, whichever is the later, a provider that is dissatisfied with the draft findings or decision issued pursuant to Subsection 15.1(a) may file a written Request for an Informal Conference with the Division's staff on a form prescribed by the Director.

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

(c) A Request for an Informal Conference must be pursued before a Request for Reconsideration can be filed pursuant to Subsection 15.3. Issues not raised in the Request for Informal Conference shall not be raised at the informal conference or in any subsequent proceeding arising from the same action of the Division, including appeals pursuant to 33 V.S.A. §909.

(d) Should no timely Request for an Informal Conference be filed within the time period specified in Subsection 15.2(a), the Division's draft findings and/or decision are final and no longer subject to administrative review or judicial appeal.

### 15.3 Request for Reconsideration

(a) A provider that is aggrieved by an official action issued pursuant to Subsection 15.2(b) may file a Request for Reconsideration.

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

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

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

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

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

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

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

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

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

(h) The Director shall issue a Final Order on Request for Reconsideration no later than 30 days after the record closes. Pending the

issuance of a final order, the official action issued pursuant to subsection 15.2(b) shall be used as the basis for setting an interim rate from the first day of the calendar quarter following its issuance. Final orders shall be effective from the effective date of the official action.

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

**15.4 Appeals from Final Orders of the Division**

(a) Within 30 days of the date thereof, a nursing facility aggrieved by a Final Order of the Division may file an appeal pursuant to 33 V.S.A. §909(a) and Subsections 15.5, 15.6 and 15.7 of this rule.

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

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

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

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

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

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

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

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

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

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

(a) No appeal may be taken under this section when the remedy requested is retrospective relief from the operation of a provision of this rule or such other relief as may be outside the power of the Secretary to order. Such relief may be pursued by an appeal to the Vermont Supreme Court or Superior

Court pursuant to 33 V.S.A. §909(a)(1) and (2), or prospectively by a request for rulemaking pursuant 3 V.S.A. §806.

(b) Appeals under this section shall be governed by the relevant provisions of the Administrative Procedures Act, 3 V.S.A. §§809-815.
(c) Proceedings under this section shall be initiated by filing two copies of a written Request for Administrative Review with the Division, on forms prescribed therefor.

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

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

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

(1) the simplification of the issues,

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

(3) the appropriateness of prefiled testimony,

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

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

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

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

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

(j) At the time the independent appeals officer makes her or his Recommendation, she or he shall transmit the docket file to the Secretary. The Secretary shall retain the file

for a period of at least one year from the date of the Final Determination in the docket. In the event of an appeal of the Secretary's Final Determination to the Vermont Supreme Court or to Superior Court, the Secretary shall make disposition of the file as required by the applicable rules of civil and appellate procedure.

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

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

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

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

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

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

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

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

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

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

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

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

### 15.8 Settlement Agreements

The Director may agree to settle reviews and appeals taken pursuant to Subsections 15.3 and 15.5, and, with the approval of the Secretary, may agree to settle other appeals taken pursuant to 33 V.S.A. §909 and any other litigation involving the Division on such reasonable terms as she or he may deem appropriate to the circumstances of the case.

## 16 DEFINITIONS AND TERMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**FASB:** Financial Accounting Standards Board.

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

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

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

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

member's employment or costs of obtaining a GED.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## 17 TRANSITIONAL PROVISIONS

Notwithstanding any other provisions of these rules, the amendments to these rules effective March 6, 2015 shall be applied to payments for services rendered on or after March 1, 2015.

## 17.1 Companion Aide Pilot Project

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

The work of the Companion Aides funded by this pilot program must comply with the job description detailed in the Companion Aide application. The selected nursing facilities may have the Companion Aide work any shift.

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

(a) Selection Process

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

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

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

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

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

(b) Rate Adjustment Calculations and Procedures

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

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

(3) The number of total beds filled shall equal the total number of residents reported

on the June 15, 2014 MDS picture date (Q2 2014) summary report supplied to the Division of Licensing and Protection.

(c) Inflation of Rate Adjustments

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

(d) End of Adjustment and Special Nursing Rebase Provisions

(1) The adjustments in this Section will be terminated as of July 1, 2017 when Nursing Care costs are rebased to base year 2015. This will be the first year when the costs of the Companion Aides will be in the facility's base year costs.

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

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

(e) Ongoing Reporting Requirements

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

Clean Text

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

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

**Emergency Rule**
**May 2022**

# TABLE OF CONTENTS

Cite as Vermont Division of Rate Setting Rules (V.D.R.S.R.)

# 1 GENERAL PROVISIONS

## 1.1 Purpose

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

## 1.2 Scope

These rules apply to all privately owned nursing facilities and state nursing facilities providing services to Medicaid residents. Long-term care services in swing-bed hospitals, and Intermediate Care Facilities for the Mentally Retarded are reimbursed under different methods and standards. Swing-bed hospitals are reimbursed pursuant to 42 U.S.C. §1396l(b)(1). Intermediate Care Facilities for the Mentally Retarded are reimbursed pursuant to the *Regulations Governing the Operation of Intermediate Care Facilities for the Mentally Retarded* adopted by the Agency and are subject to the Division's Accounting Requirements (Section 2) and Financial Reporting (Section 3).

## 1.3 Authority

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

## 1.4 General Description of the Rate Setting System

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

## 1.5 Requirements for Participation in Medicaid Program

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

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

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

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

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

(c) Medicaid payments shall not be made to any facility that fails to meet all the requirements of Subsection 1.5(a).

### 1.6 Responsibilities of Owners

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

### 1.7 Duties of the Owner

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

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

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

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

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

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

(f) Notwithstanding any other provision of these rules, any provider that fails to make a complete cost report filing within the time prescribed in subsection 3.3(a) or fails to file any other materials requested by the Division within the time prescribed shall receive no increase to its Medicaid rate until the first day of the calendar quarter after a complete cost report or the requested materials are filed, unless within an extension of time previously approved by the Division.

### 1.8 Powers and Duties of the Division and the Director

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

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

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

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

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

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

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

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

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

(a) The Division of Licensing and Protection of the Department of Disabilities, Aging and Independent Living shall receive from providers resident assessments on forms it specifies. The Department of Disabilities, Aging and Independent Living shall process this information and shall periodically, but no less frequently than quarterly, provide the Division of Rate Setting with the average case-mix scores of each facility based upon the federal RUG IV classification system (48 group version). This score will be used in the quarterly determination of the Nursing Care portion of the rate.

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

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

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

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

(c) When by these rules or by a notice given thereunder, an act is required or allowed to be done at or within a specified time, the relevant administrative officer, for just cause shown, may at any time in her or his discretion, with or without motion or notice, order the period enlarged. This subsection shall not apply to the time limits for appeals to the Vermont Supreme Court or Superior Court from Final Orders of the Division or Final Determinations of the Secretary, which are governed by the Vermont Rules of Appellate Procedure and the Vermont Rules of Civil Procedure respectively.

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

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

### 1.11 Representation in All Matters before the Division

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

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

### 1.12 Severability

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

### 1.13 Effective Date

(a) These rules are effective from January 29, 1992, (as amended June 18, 1993, July 1, 1994, January 4, 1995, January 1, 1996, January 1, 1997, July 1, 1998, May 1, 1999, July 1, 1999, August 1, 1999, July 1, 2001, November 1, 2002, May 1, 2004, July 1, 2004, July 1, 2005, October 29, 2007, August 25, 2008, April 1, 2011, September 17, 2012, September 9, 2013, and March 6, 2015).

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

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

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

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

## 2 ACCOUNTING REQUIREMENTS

### 2.1 Accounting Principles

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

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

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

The provider shall retain all such documentation for audit purposes.

## 2.2 Procurement Standards

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

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

## 2.3 Cost Allocation Plans and Changes in Accounting Principles

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

(a) [Repealed]

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

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

(d) [Repealed]

(e) [Repealed]

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

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

(1) Nursing salaries and supplies - direct cost,

(2) Plant operations - square footage,

(3) Utilities - square footage,

(4) Laundry - pounds of laundry,

(5) Dietary -resident days,

(6) Administrative and General - accumulated costs,

(7) [Repealed]

(8) Property and Related - square footage,

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

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

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

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

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

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

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

### 2.4 Substance Over Form

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

### 2.5 Record Keeping and Retention of Records

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

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

(c) The provider shall maintain all such records for at least six years from the date of filing, or the date upon which the fiscal and statistical records were to be filed, whichever is the later. The Division shall keep all cost reports, supporting documentation submitted by the provider, correspondence, workpapers and other analyses supporting Summaries of Findings for six years. In the event of litigation or appeal involving rates established under these regulations, the provider and Division shall retain all records which are in any way related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.

(d) Pursuant to 33 V.S.A. §908(a), all documents and other materials filed with the Division are public information, except for individually identifiable health information protected by law or the policies, practices, and procedures of the Agency of Human Services. With the exception of the administrator's salary, the salaries and wages of individual employees shall not be made public.

## 3 FINANCIAL REPORTING

### 3.1 [Repealed]

### 3.2 Uniform Cost Reports

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

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

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

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

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

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

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

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

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

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

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

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

### 3.3 Adequacy and Timeliness of Filing

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

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

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

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

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

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

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

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

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

### 3.4 Review of Cost Reports by Division

(a) Uniform Desk Review

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

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

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

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

(b) On-site Audit

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

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

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

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

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

### 3.5 Settlement of Cost Reports

(a) A cost report is settled if there is no request for reconsideration of the Division's findings or, if such request was made, the

Division has issued a final order pursuant to Subsection 15.3 of these rules.

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

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

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

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

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

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

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

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

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

## 4 DETERMINATION OF ALLOWABLE COSTS FOR NURSING FACILITIES

### 4.1 Provider Reimbursement Manual and GAAP

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

### 4.2 General Cost Principles

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

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

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

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

### 4.3 Non-Recurring Costs

(a) Non-recurring costs shall include:

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

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

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

(b) A non-recurring cost shall be capitalized and amortized and carried as an on-going adjustment beginning with the first quarterly rate change after the settlement of the cost report for a period of three years.

### 4.4 Interest Expense

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

(b) "Necessary requires that:

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

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

(3) Cash and cash equivalents include:

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

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

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

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

(4) Cash and cash equivalents exclude:

(i) funded depreciation recognized by the Division,

(ii) restricted grants and gifts.

(5) Interest income offset.

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

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

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

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

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

(c) "Proper" requires that:

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

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

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

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

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

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

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

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

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

Equals: The limits on borrowings related to fixed assets.

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

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

(i) Application of Principal Payments.

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

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

(j) Refinancing of indebtedness.

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

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

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

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

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

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

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

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

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

### 4.5 Basis of Property, Plant and Equipment

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

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

(1) purchase price,

(2) sales tax,

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

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

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

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

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

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

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

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

**4.6 Depreciation and Amortization of Property, Plant and Equipment**

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

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

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

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

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

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

**4.7 Change in Ownership of Depreciable Assets - Sales of Facilities**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) the fair market value of the assets,

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

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

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

(i) the fair market value of the assets,

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

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

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

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

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

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

**4.8 [Repealed]**

**4.9 Leasing Arrangements for Property, Plant and Equipment**

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

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

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

**4.10 Funding of Depreciation**

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

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

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

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

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

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

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

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

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

**4.11 Adjustments for Large Asset Acquisitions and Changes of Ownership**

(a) Large Asset Acquisitions

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

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

(b) Changes of Ownership

(1) Application shall also be made under this subsection, no later than 30 days after the execution of a purchase and sale agreement or other binding contract, or the receipt of a Certificate of Need pursuant to 18 V.S.A. §9434, for changes in basis resulting from a change in ownership of depreciable assets recognized by the Division pursuant to Subsection 4.7. The Division may make related adjustments to the Property and Related rate component.

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

(c) Except in circumstances determined by the Division to constitute an emergency precluding a 60 day notice period, a provider applying for an adjustment pursuant to this subsection is required to give 60 days written notice to the Division prior to the purchase of the asset. Such applications shall be exempt from the materiality test set out in subsection 8.7(b), but are subject to the other provisions of subsection 8.7. The burden is on the provider to document all information applicable to this adjustment and to demonstrate that any costs to be incurred are necessary and reasonable. When applicable, such documentation shall include the Certificate of Need application and all supporting financial information. The Division shall review the application and issue draft findings approving, denying, or proposing modifications to the adjustment applied for within 60 days of receipt of all information required.

**4.12 [Repealed]**

### 4.13 Advertising Expenses

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

### 4.14 Barber and Beauty Service Costs

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

### 4.15 Bad Debt, Charity and Courtesy Allowances

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

### 4.16 Child Day Care

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

### 4.17 Community Service Activities

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

### 4.18 Dental Services

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

### 4.19 Legal Costs

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

### 4.20 Litigation and Settlement Costs

(a) Civil and criminal litigation -

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

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

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

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

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

**4.21 Motor Vehicle Allowance**

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

**4.22 Non-Competition Agreement Costs**

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

**4.23 Compensation of Owners, Operators, or their Relatives**

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

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

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

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

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

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

**4.24 Management Fees and Home Office Costs**

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

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

**4.25 Membership Dues**

Reasonable and necessary membership dues, including any portions used for lobbying

activities, shall be considered Medicaid allowable costs, provided the organization's function and purpose are directly related to providing resident care.

**4.26 Post-Retirement Benefits**

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

**4.27 Public Relations**

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

**4.28 Related Party**

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

**4.29 Revenues**

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

**4.30 Travel/Entertainment Costs**

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

**4.31 Transportation Costs**

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

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

**4.32 Services Directly Billable**

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

## 5 REIMBURSEMENT STANDARDS

**5.1 Prospective Case-Mix Reimbursement System**

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

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

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

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

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

(c) Per diem rates shall be prospectively determined for the rate year based on the allowable operating costs of a facility in a Base Year, plus property and related and ancillary costs from the most recently settled cost report, calculated as described in Subsection 9.2.

### 5.2 Retroactive Adjustments to Prospective Rates

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

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

(1) as an adjustment pursuant to Sections 8 and 10;

(2) in response to a decision by the Secretary pursuant to Subsection 15.5 or to an order of a court of competent jurisdiction, whether or not that order is the result of a decision on the merits, or as the result of a settlement pursuant to Subsection 15.8;

(3) for mechanical computation or typographical errors;

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

(5) as a result of revised findings resulting from the reopening of a settled cost report pursuant to Subsection 3.5;

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

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

(8) when a special rate is revised pursuant to subsection 14.1(e)(2) or

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

### 5.3 Lower of Rate or Charges

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

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

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

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

(2) the first day of the quarter after the effective date of the change to the provider's charges if the change to the provider's charges is not effective on the first day of the quarter, or

(3) the first day of the following quarter after the receipt by the Division of notification of the change pursuant to paragraph (b).

### 5.4 Interim Rates

(a) The Division may set interim rates for any or all facilities. The notice of an interim rate is not a final order of the Division and is not subject to review or appeal pursuant to any provision of these rules or 33 V.S.A. §909.

(b) Any overpayments or underpayments resulting from the difference between the interim and final rates will be either refunded by the provider or paid to the provider.

### 5.5 Upper Payment Limits

(a) Aggregate payments to nursing facilities pursuant to these rules may not exceed the limits established for such payment in 42 C.F.R. §447.272.

(b) If the Division projects that Medicaid payments to nursing facilities in the aggregate will exceed the Medicare upper limit, the Division shall adopt a rule limiting some or all of the payments to providers to the level that would reduce the aggregate payments to the Medicare upper limit.

### 5.6 Base Year

(a) A Base Year shall be a calendar year, January through December.

(b) All costs shall be rebased on July 1, 2007. Subsequent rebasing for Nursing Care costs shall occur two years after the last rebase of such costs. All costs shall be rebased no less frequently than every four years.

(c) For the purposes of rebasing, the Director may require individual facilities to file special cost reports covering the calendar year when this is not the facility's fiscal year or the Division may use the facility's fiscal year cost report adjusted by the inflation factors in subsection 5.8 to the Base Year. The Director may require audited financial statements for the special cost reporting period. The costs of preparing the special cost report and audited financial statements are the responsibility of the provider, without special reimbursement; however, for reporting purposes, these costs are allowable.

(d) The determination of a Base Year shall be subject of a notice of practices and procedures pursuant to Subsection 1.8(d) of these rules.

### 5.7 Occupancy Level

(a) A facility should maintain an annual average level of occupancy at a minimum of 90 percent of the licensed bed capacity.

(b) For facilities with less than 90 percent occupancy, the number of total resident days at 90 percent of licensed capacity shall be used, pursuant to section 7, in determining the per diem rate for all categories except the Nursing Care and Ancillary categories.

(c) The 90 percent minimum occupancy provision in paragraph (b) shall be waived for facilities with 20 or fewer beds or terminating facilities pursuant to Subsection 5.10, and when appropriate, for facilities operating under a receivership pursuant to Subsection 8.3.

(d) Decreasing the Number of Licensed Beds – For any facility that operated at less than 90 percent occupancy during the period used as the cost basis for any rate component subject

to subsection (b) which subsequently reduces the number of licensed beds, the minimum occupancy shall be calculated based on the number of the facility's licensed beds on the first day of the quarter after the facility notifies the Division of such reduction.

### 5.8 Inflation Factors

The Director shall use the most recent publication of the Health Care Cost Service available June 1 in the calculation of inflation factors, whether for rebase inflation calculations or annual inflation calculations. Different inflation factors are used to adjust different rate components. Subcomponents of each inflation factor are weighted in proportion to the percentage of actual allowable costs incurred by Vermont facilities for specific subcomponents of the relevant cost component. For example, if a cost in the Nursing Care cost component is 83.4 percent attributable to salaries and wages and 16.6 percent attributable to employee benefits, the weights for the two subcomponents of the Nursing Care inflation factor shall be 0.834 and 0.166 respectively. The weights for each inflation factor shall be recalculated no less frequently than each time the relevant cost category is rebased.

(a) The Nursing Care rate component shall be adjusted by an inflation factor that uses two price indexes to account for estimated economic trends with respect to two subcomponents of nursing costs: wages and salaries, and benefits. The price indexes for each subcomponent are the wages and salaries portion of the Health-Care Cost Service NHMB, and the employee benefits portion of the NHMB, respectively. An additional adjustment of one percentage point shall be made for every 12 month period, prorated for fractions thereof, from the midpoint of the base year to the midpoint of the rate year.

For the four rate quarters beginning July 1, 2021, October 1, 2021, January 1, 2022, and April 1, 2022, the Nursing Care rate component shall be increased by an additional 9.18% to account for sustained increases in the rate component.

(b) The Resident Care Rate Component shall be adjusted by an inflation factor that uses four price indexes to account for estimated economic trends with respect to the subcomponents of Resident Care costs: wages and salaries, employee benefits, utilities, and food and all other Resident care costs. The price indexes for each subcomponent are: the wages and salaries portion of the Health-Care Cost Service NHMB, the employee benefits portion of the NHMB, the utilities portion of the NHMB, and the food portion of the NHMB respectively.

(c) The Indirect rate component shall be adjusted by an inflation factor that uses three price indexes to account for estimated economic trends with respect to three subcomponents of Indirect costs: wages and salaries, employee benefits, and all other indirect costs. The price indexes for each subcomponent are: the wages and salaries portion of the Health-Care Cost Service NHMB, the employee benefits portion of the NHMB and the NECPI-U (all items), respectively.

(d) The Director of Nursing rate component shall be adjusted by an inflation factor that uses two price indexes to account for estimated economic trends with respect to two subcomponents of Director of Nursing costs: wages and salaries and employee benefits. The price indexes for each subcomponent are: the wages and salaries portion of the Health-Care Cost Service NHMB, and the employee benefits portion of the NHMB, respectively.

(e) Pursuant to Subsection 1.8(d), the Division shall issue a description of the practices and procedures used to calculate and apply the Inflation Factors.

### 5.9 Costs for New Facilities

(a) For facilities that are newly constructed, newly operated as nursing facilities, or new to the Medicaid program, the prospective case-mix rate shall be determined based on budget cost reports submitted to the Division and the greater of the estimated resident days for the rate year or the resident days equal to 90 percent occupancy of all beds used or intended to be used for resident care at any time within the budget cost reporting period. This rate shall remain in effect no longer than one year from the effective date of the new rate. The principles on allowability of costs and existing limits in Sections 4 and 7 shall apply.

(b) The costs reported in the budget cost report shall not exceed reasonable budget projections (adjusted for inflation and changes in interest rates as necessary) submitted in connection with the Certificate of Need.

(c) Property and related costs included in the rate shall be consistent with the property and related costs in the approved Certificate of Need.

(d) At the end of the first year of operation, the prospective case-mix rate shall be revised based on the provider's actual allowable costs as reported in its annual cost report filed pursuant to subsection 3.2 for its first full fiscal year of operation.

### 5.10 Costs for Terminating Facilities

(a) When a nursing facility plans to discontinue all or part of its operation, the Division may adjust its rate so as to ensure the protection of the residents of the facility.

(b) A facility applying for an adjustment to its rate pursuant to this subsection must have a transfer plan approved by the Department of Disabilities, Aging and Independent Living, a copy of which shall be supplied to the Division.

(c) An application under this subsection shall be made on a form prescribed by the Director and shall be accompanied by a financial plan demonstrating how the provider will meet its obligations set out in the approved transfer plan.

(d) In approving such an application the Division may waive the minimum occupancy requirements in Subsection 5.7, the limitations on costs in Section 7, or make such other reasonable adjustments to the facility's reimbursement rate as shall be appropriate in the circumstances. The adjustments made under this subsection shall remain in effect for a period not to exceed six months.

## 6 BASE YEAR COST CATEGORIES FOR NURSING FACILITIES

### 6.1 General

In the case-mix system of reimbursement, allowable costs are grouped into cost categories. The accounts to be used for each cost category shall be prescribed by the Director. The Base Year costs shall be grouped into the following cost categories:

### 6.2 Nursing Care Costs

(a) Allowable costs for the Nursing Care component of the rate shall include actual costs of licensed personnel providing direct resident care, which are required to meet federal and state laws as follows:

(1) registered nurses,
(2) licensed practical nurses,
(3) certified or licensed nurse aides, including wages related to initial and on-going nurse aide training as required by OBRA,
(4) contract nursing,
(5) the MDS coordinator,
(6) fringe benefits, including child day care.

(b) Costs of bedmakers, geriatric aides, transportation aides, paid feeding/dining assistants, ward clerks, medical records

librarians and other unlicensed staff will not be considered nursing costs. The salary and related benefits of the position of Director of Nursing shall be excluded from the calculation of allowable nursing costs and shall be reimbursed separately.

### 6.3 Resident Care Costs

Allowable costs for the Resident Care component of the rate shall include reasonable costs associated with expenses related to direct care. The following are Resident Care costs:

(a) food, vitamins and food supplements,
(b) utilities, including heat, electricity, sewer and water, garbage and liquid propane gas,
(c) activities personnel, including recreational therapy and direct activity supplies,
(d) Medical Director, Pharmacy Consultant, Geriatric Consultant, and Psychological/psychiatric Consultant,
(e) counseling personnel, chaplains, art therapists and volunteer stipends,
(f) social service worker,
(g) employee physicals,
(h) wages for paid feeding/dining assistants only for those hours that they are actually engaged in assisting residents with eating,
(i) fringe benefits, including child day care,
(j) such other items as the Director may prescribe by a practice and procedure issued pursuant to subsection 1.8(d).

### 6.4 Indirect Costs

(a) Allowable costs for the indirect component of the rate shall include costs reported in the following functional cost centers on the facility's cost report, including those extracted from a facility's cost report or the cost report of an affiliated hospital or institution.

(1) fiscal services,
(2) administrative services and professional fees,
(3) plant operation and maintenance,
(4) grounds,
(5) security,
(6) laundry and linen,
(7) housekeeping,
(8) medical records,
(9) cafeteria,
(10) seminars, conferences and other in-service training (except tuition for college credit in a discipline related to the individual staff member's employment or costs of obtaining a GED which shall be treated as fringe benefits),
(11) dietary excluding food,
(12) motor vehicle,
(13) clerical, including ward clerks,
(14) transportation (excluding depreciation),
(15) insurances (director and officer liability, comprehensive liability, bond indemnity, malpractice, premise liability, motor vehicle, and any other costs of insurance incurred or required in the care of residents that has not been specifically addressed elsewhere),
(16) office supplies/telephone,
(17) conventions and meetings,
(18) EDP bookkeeping/payroll,
(19) fringe benefits including child day care.

(b) All expenses not specified for inclusion in another cost category pursuant to these rules shall be included in the Indirect Costs category, unless the Director at her/his discretion specifies otherwise in the instructions to the cost report, the chart of accounts, or by the issuance of a practice and procedure. For nursing facility rate setting, the costs of prescription drugs are not allowable.

### 6.5 Director of Nursing

Allowable costs associated with the position of Director of Nursing shall include reasonable salary for one position and associated fringe benefits, including child day care.

### 6.6 Property and Related

(a) The following are Property and Related costs:

(1) depreciation on buildings and fixed equipment, major movable equipment, minor equipment, computers, motor vehicle, land improvements, and amortization of leasehold improvements and capital leases,
(2) interest on capital indebtedness,
(3) real estate leases and rents,
(4) real estate/property taxes,
(5) all equipment irrespective of whether it is capitalized, expensed, or rented,
(6) fire and casualty insurance,
(7) amortization of mortgage acquisition costs.

(b) For a change in services, facility, or a new health care project with projected property and related costs of $250,000 or more, providers shall give written notice to the Division no less than 60 days before the commencement of the project. Such notice shall include a detailed description of the project and detailed estimates of the costs.

### 6.7 Ancillaries

(a) The following are ancillary costs:

(1) All physical, speech, occupational, respiratory, and IV therapy services and therapy supplies (excluding oxygen) shall be considered ancillaries. Medicaid allowable costs shall be based on the cost-to-charge ratio for these services. These therapy services shall not be allowable for Medicaid reimbursement pursuant to this subsection unless:

(i) the services are provided pursuant to a physician's order,

(ii) the services are provided by a licensed therapist or other State certified or registered therapy assistant, or qualified IV professional, or other therapy aides,

(iii) the services are not reimbursable by the Medicare program, and

(iv) the provider records charges by payor class for all units of these services.

(2) Medical supplies, whether or not the provider customarily records charges.

(i) Medical supplies shall include, but are not limited to: oxygen, disposable catheters, catheters, colostomy bags, drainage equipment, trays and tubing.

(ii) Medical supplies shall not include rented or purchased equipment, with the exception of rented or purchased oxygen concentrators, which shall be included in medical supplies.

(3) Over-the-counter drugs. All drug costs may be disallowed for providers commingling the costs of prescription drugs (which are not allowable) and over-the-counter drugs.

(4) Incontinent Supplies and Personal Care Items: including adult diapers, chux and other disposable pads, personal care items, such as toothpaste, shampoo, body powder, combs, brushes, etc.

(5) Dialysis Transportation. The costs of transportation for Medicaid residents receiving kidney dialysis shall be included in the ancillary cost category. Allowable costs may include contract or other costs, but shall not include employee salaries or wages or cost associated with the use of provider-owned vehicles.

(6) Overhead costs related to ancillary services and supplies are included in ancillary costs.

(b) [Repealed]

## 7 CALCULATION OF COSTS, LIMITS AND RATE COMPONENTS FOR NURSING FACILITIES

Base year costs, rates, and category limits are calculated pursuant to this section. The Medicaid per diem payment rate for each facility is calculated pursuant to Section 9.

### 7.1 Calculation of Per Diem Costs

Per diem costs for each cost category, excluding the Nursing Care and Ancillary cost categories, are calculated by dividing allowable costs for each case-mix category by the greater of actual bed days of service rendered, including revenue generating hold/reserve days, or the number of resident days computed using the minimum occupancy at 90 percent of the licensed bed capacity during the cost period under review calculated pursuant to subsection 5.7.

### 7.2 Nursing Care Component

(a) Case-Mix Weights.

There are 48 case-mix resident classes. Each case-mix class has a specific case-mix weight as follows:

| Group Code | Case-Mix Weight | Description |
|---|---|---|
| ES3 | 3.00 | Extensive Services |
| ES2 | 2.23 | Extensive Services |
| ES1 | 2.22 | Extensive Services |
| RAE | 1.65 | Rehabilitation |
| RAD | 1.58 | Rehabilitation |
| RAC | 1.36 | Rehabilitation |
| RAB | 1.10 | Rehabilitation |
| RAA | 0.82 | Rehabilitation |
| HE2 | 1.88 | Special Care High |
| HE1 | 1.47 | Special Care High |
| HD2 | 1.69 | Special Care High |
| HD1 | 1.33 | Special Care High |
| HC2 | 1.57 | Special Care High |
| HC1 | 1.23 | Special Care High |
| HB2 | 1.55 | Special Care High |
| HB1 | 1.22 | Special Care High |
| LE2 | 1.61 | Special Care Low |
| LE1 | 1.26 | Special Care Low |
| LD2 | 1.54 | Special Care Low |
| LD1 | 1.21 | Special Care Low |
| LC2 | 1.30 | Special Care Low |
| LC1 | 1.02 | Special Care Low |
| LB2 | 1.21 | Special Care Low |
| LB1 | 0.95 | Special Care Low |
| CE2 | 1.39 | Clinically Complex |
| CE1 | 1.25 | Clinically Complex |
| CD2 | 1.29 | Clinically Complex |
| CD1 | 1.15 | Clinically Complex |
| CC2 | 1.08 | Clinically Complex |
| CC1 | 0.96 | Clinically Complex |
| CB2 | 0.95 | Clinically Complex |
| CB1 | 0.85 | Clinically Complex |
| CA2 | 0.73 | Clinically Complex |
| CA1 | 0.65 | Clinically Complex |
| BB2 | 0.81 | Behavioral Symptoms Plus Cognitive Performance |
| BB1 | 0.75 | Behavioral Symptoms Plus Cognitive Performance |
| BA2 | 0.58 | Behavioral Symptoms Plus Cognitive Performance |
| BA1 | 0.53 | Behavioral Symptoms Plus Cognitive Performance |
| PE2 | 1.25 | Reduced Physical Function |
| PE1 | 1.17 | Reduced Physical Function |
| PD2 | 1.15 | Reduced Physical Function |
| PD1 | 1.06 | Reduced Physical Function |
| PC2 | 0.91 | Reduced Physical Function |
| PC1 | 0.85 | Reduced Physical Function |
| PB2 | 0.70 | Reduced Physical Function |
| PB1 | 0.65 | Reduced Physical Function |
| PA2 | 0.49 | Reduced Physical Function |
| PA1 | 0.45 | Reduced Physical Function |

(b) Average case-mix score

The Department of Disabilities, Aging and Independent Living's Division of Licensing and Protection shall compute each facility's average case-mix score.

(1) The Division of Licensing and Protection shall periodically, but no less

frequently than quarterly, certify to the Division of Rate Setting the average case-mix score for those residents of each facility whose room and board (excluding resident share) is paid for solely by the Medicaid program.

(2) For the Base Year, the Division of Licensing and Protection shall certify the average case-mix score for all residents.

(c) Nursing Care cost per case-mix point.
Each facility's Nursing Care cost per case-mix point will be calculated as follows:

(1) Using each facility's Base Year cost report, the total allowable Nursing Care costs shall be determined in accordance with Subsection 6.2.

(2) Each facility's Standardized Resident Days shall be computed by multiplying total Base Year resident days by that facility's average case-mix score for all residents for the four quarters of the cost reporting period under review.

(3) The per diem nursing care cost per case-mix point shall be computed by dividing total Nursing Care costs by the Base Year Standardized Resident Days for that Base Year.

(d) Per diem limits on the Base Year allowable Nursing Care rate per case-mix point:

(1) The Division shall array all nursing care facilities' allowable Base Year per diem Nursing Care costs per case-mix point, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high. These costs shall be limited to the cost at the ninetieth percentile, calculated using the percentile spreadsheet function.

(2) Each facility's Base Year Nursing Care rate per case-mix point shall be the lesser of the limit in subparagraph (1) or the facility's allowable Nursing Care cost per case-mix point.

### 7.3 Resident Care Base Year Rate

Resident Care Base Year rates shall be computed as follows:

(a) Using each facility's Base Year cost report, the provider's Base Year total allowable Resident Care costs shall be determined in accordance with Subsection 6.3.

(b) The Base Year per diem allowable Resident Care costs for each facility shall be calculated by dividing the Base Year total allowable Resident Care costs by total Base Year resident days.

(c) The Division shall array all nursing facilities' Base Year per diem allowable Resident Care costs, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high and identify the median.

(d) The per diem limit shall be the median plus five percent.

(e) Each facility's Base Year Resident Care per diem rate shall be the lesser of the limit set in paragraph (d) or the facility's Base Year per diem allowable Resident Care costs.

### 7.4 Indirect Base Year Rate

Indirect Base Year rates shall be computed as follows:

(a) Using each facility's Base Year cost report, each provider's Base Year total allowable Indirect costs shall be determined in accordance with Subsection 6.4.

(b) The Base Year per diem allowable Indirect costs for each facility shall be calculated by dividing the Base Year total allowable Indirect costs by total Base Year resident days.

(c) The Division shall array all nursing facilities' Base Year per diem allowable Indirect costs, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high and identify the median.

(d) The per diem limit shall be set as follows:

(1) For special hospital-based nursing facilities, the limit shall be 137 percent of the median.

(2) For all other privately-owned nursing facilities, the limit shall be the median plus five percent.

(e) Each provider's Base Year Indirect per diem rate shall be the lesser of the limit in paragraph (d) or the facility's Base Year per diem allowable Indirect costs.

### 7.5 Director of Nursing Base Year Rate

The Director of Nursing Base Year per diem rates shall be computed as follows:

(a) Using each facility's Base Year cost report, total allowable Base Year Director of Nursing costs shall be determined in accordance with Subsection 6.5.

(b) Each facility's Base Year per diem allowable Director of Nursing costs shall be calculated by dividing the Base Year total allowable Director of Nursing costs by total Base Year resident days.

(c) The Director of Nursing per diem rate shall be the facility's Base Year per diem allowable Director of Nursing costs calculated pursuant to this subsection.

### 7.6 Ancillary Services Rate

(a) The Ancillary per diem rate shall be computed as follows:

(1) Medicaid Ancillary costs shall be determined in accordance with subsection 6.7.

(2) Using each facility's most recently settled cost report, the per diem Ancillary rate shall be the sum of the following per diem costs calculated as follows:

(i) Costs for therapy services per diem, including IV therapy, shall be calculated by dividing allowable Medicaid costs by the number of related Medicaid resident days less Medicaid hold days.

(ii) Dialysis transportation costs per diem shall be calculated by dividing the allowable costs for Vermont Medicaid residents by the number of Vermont Medicaid resident days less Vermont Medicaid hold days.

(iii) Costs for medical supplies, over-the-counter drugs, and incontinent supplies and personal care items per diem shall be calculated by dividing allowable costs, by total resident days less hold days.

(b) Any change to the Ancillary per diem rate shall be implemented at the time of the first quarterly case-mix rate recalculation after the cost report is settled.

### 7.7 Property and Related Per Diem

The Property and Related per diem rate shall be computed as follows:

(a) Using each facility's most recently settled annual cost report, total allowable Property and Related costs shall be determined in accordance with Subsection 6.6.

(b) Using each facility's most recently settled cost report, the per diem property and related costs shall be calculated by dividing allowable property and related costs by total resident days. Any change to the property and related per diem rate shall be implemented at the time of the first quarterly

case-mix rate recalculation after the cost report is settled.

### 7.8 Limits Final

Once a final order has been issued for all facilities' Base Year cost reports, notwithstanding any subsequent changes to the cost report findings, resulting from a reopening, appeal, or other reason, the limits set pursuant to subsections 7.2(d)(2), 7.3(d), and 7.4(d) will not change until nursing home costs are rebased pursuant to 5.6(b), except for annual adjustment by the inflation factors or a change in law necessitating such a change.

## 8 ADJUSTMENTS TO RATES

### 8.1 Change in Services

The Division, on application by a provider, may make an adjustment to the prospective case-mix rate for additional costs which are directly related to:

(a) a new health care project previously approved under the provisions of 18 V.S.A. §9434. Costs greater than those approved in the Certificate of Need (as adjusted for inflation) will not be considered when calculating such an adjustment,

(b) a change in services, facility, or new health care project not covered under the provisions of 18 V.S.A. §9434, if such a change has previously been approved by the Division, or

(c) with the prior approval of the Division, a reduction in the number of licensed beds.

### 8.2 Change in Law

The Division may make or a provider may apply for an adjustment to a facility's prospective case-mix rate for additional costs that are a necessary result of complying with changes in applicable federal and state laws, and regulations, or the orders of a State agency that specifically requires an increase in staff or other expenditures.

### 8.3 Facilities in Receivership

(a) The Division, on application by a receiver appointed pursuant to state or federal law, may make an adjustment to the prospective case-mix rate of a facility in receivership for the reasonable and necessary additional costs to the facility incurred during the receivership.

(b) On the termination of the receivership, the Division shall recalculate the prospective case-mix rate to eliminate this adjustment.

### 8.4 Efficiency Measures

The Division, on application by a provider, may make an adjustment to a prospective case-mix rate for additional costs which are directly related to the installation of energy conservation devices or the implementation of other efficiency measures, if they have been previously approved by the Division.

### 8.5 Interest Rates

(a) A provider may apply for an adjustment to the Property and Related rate, or the Division may initiate an adjustment if there are cumulative interest rate increases or decreases of more than one-half of one percentage point because of existing financing agreements with a balloon payment or a refinancing clause that forces a mortgage to be refinanced at a different interest rate, or because of a variable rate of adjustable rate mortgages.

(b) A provider with an interest rate adjustment shall notify the Division of any change in the interest rate within 10 days of its receipt of notice of that change. The Division may rescind all interest rate adjustments of any facility failing to file a timely notification pursuant to this subsection for a period of up to two years.

### 8.6 Emergencies and Unforeseeable Circumstances

(a) The Division, on application by a provider, may make an adjustment to the prospective case-mix rate under emergencies and unforeseeable circumstances, such as damage from fire or flood.

(b) Providers must carry sufficient insurance to address adequately such circumstances.

### 8.7 Procedures and Requirements for Rate Adjustments

(a) Application for a rate adjustment pursuant to this section should be made as follows. Approval of any application for a rate adjustment under this section is at the sole discretion of the Director.

(b) Except for applications made pursuant to subsection 4.11, no application for a rate adjustment should be made if the change to the rate would be smaller than one percent of the rate in effect at the time.

(c) Application for a Rate Adjustment shall be made on a form prescribed by the Director and filed with the Division and shall be accompanied by all documents and proofs determined necessary for the Division to make a decision.

(d) The burden of proof is at all times on the provider to show that the costs for which the adjustment has been requested are reasonable, necessary and related to resident care.

(e) The Division may grant or deny the Application, or make an adjustment modifying the provider's proposal. If the materials filed by the provider are inadequate to serve as a basis for a reasonable decision, the Division shall deny the Application, unless additional proofs are submitted.

(f) The Division shall not be bound in considering other Applications, or in determining the allowability of reported costs, by any prior decision made on any Application under this section. Such decisions shall have no precedential value either for the applicant facility or for any other facility. Principles and decisions of general applicability shall be issued as a Division practice or procedure, pursuant to Section 1.8(d).

(g) For adjustments requiring prior approval of the Division, such approval should be sought before the provider makes any commitment to expenditures. An Application for Prior Approval is subject to the same requirements as an Application for a Rate Adjustment under this section.

(h) Rate adjustments made under this section shall be effective from the first day of the quarter following the date of the final order on the application or following the date the assets are actually put into service, whichever is the later, or, at the discretion of the Division, the first day of the quarter immediately preceding the final order and may be continued, at the discretion of the Division, notwithstanding a general rebase of costs. Costs which are the basis for a continuing rate adjustment shall not be included in the cost categories used as the basis for the other rate components.

(i) The Division may require an applicant for a rate adjustment under this section or under subsection 4.11 to file a budget cost report in support of its application.

(j) When determined to be appropriate by the Division, a budget rate may be set for the facility according to the procedures in and subject to the provisions of subsection 5.9. Appropriate cases may include, but are not limited to, changes in the number of beds, an addition to the facility, or the replacement of existing property.

(k) In calculating an adjustment under this section and subsection 4.11, the Division may take into account the effect of such

changes on all the cost categories of the facility.

(l) A revision may be made prospectively to a rate adjustment under this section and subsection 4.11 based on a "look-back" which will be computed based on a provider's actual allowable costs.

(m) In this subsection "additional costs" means the incremental costs of providing resident care directly and proximately caused by one of the events listed in this section or subsection 4.11. Increases in costs resulting from other causes will not be recognized. It is not intended that this section be used to effect a general rebase in a facility's costs.

### 8.8 Limitation on Availability of Rate Adjustments

Providers may not apply for a rate adjustment under this section for the sole reason that actual costs incurred by the facility exceed the rate of payment.

## 9 PRIVATE NURSING FACILITY AND STATE NURSING FACILITY RATES

The Medicaid per diem payment rates for nursing home services are calculated according to this section as follows:

### 9.1 Nursing Facility Rate Components

The per diem rate of reimbursement consists of the following rate components:

(a) Nursing Care
(b) Resident Care
(c) Indirect
(d) Director of Nursing
(e) Property and Related
(f) Ancillaries
(g) Adjustments (if any)

### 9.2 Calculation of the Total Rate

The total per diem rate in effect for any nursing facility shall be the sum of the rates calculated for the components listed in Subsection 9.1, adjusted in accordance with the Inflation Factors, as described in Subsection 5.8.

### 9.3 Updating Rates for a Change in the Average Case-Mix Score

(a) The Nursing Care rate component shall be updated quarterly, on the first day of January, April, July and October, for changes in the average case-mix score of the facility's Medicaid residents.

(b) The Nursing Care rate component and any part of a Section 8 adjustment that reimburses nursing costs are updated for a change in the average case-mix score for the facility's Medicaid residents. The update is calculated as follows:

(1) The Nursing Care rate component (or rate adjustment) in the current rate of reimbursement for a facility is divided by the average case-mix score used to determine the current Nursing Care rate component. This quotient is the current Nursing Care rate per case-mix point.

(2) The current Nursing Care rate component (or rate adjustment) per case-mix point is multiplied by the new average case-mix score. This product is the new Nursing Care rate component (or rate adjustment).

### 9.4 State Nursing Facilities

(a) Notwithstanding any other provisions of these rules, payment rates for state nursing facilities shall be determined retrospectively by the Division based on the reasonable and necessary costs of providing those services as determined using the cost reporting and cost finding principles set out in sections 3 and 4 of these rules.

(b) Until such time as the cost report is settled, the Division shall set an interim rate

based on an estimate of the facility's costs and census for the rate year.

(c) After reviewing the facility's cost report, the Division shall set a final rate for the fiscal year based on the facility's allowable costs. If there has been an under payment for the period the difference shall be paid to the facility. If there has been an overpayment the excess payments shall be recouped.

(d) At no time shall the final rates paid to State nursing facilities exceed the upper limits established in 42 C.F.R. §447.272.

### 9.5 Quality Incentives

Certain awards shall be made annually to facilities that provide a superior quality of care in an efficient and effective manner.

(a) These payments will be based on:

(1) objective standards of quality, which shall include resident satisfaction surveys, to be determined by the Department of Disabilities, Aging and Independent Living, and

(2) objective standards of cost efficiency determined by the Division.

(b) Supplemental payments will not be available under this subsection for any facility that does not participate in the statewide resident satisfaction survey program.

(c) Supplemental payments shall be expended by the provider to enhance the quality of care provided to Medicaid eligible residents. In determining the nature of these expenditures, the provider shall consult with the facility's Resident Council.

(d) The amount and method of distribution of the quality incentive payments shall be as follows:

(1) The quality incentive payments shall be made from a pool. The annual size of the pool shall be based on the amount of $25,000 times the number of facilities meeting the award criteria, up to a maximum of five.

(2) The pool shall be distributed among the qualifying facilities, awarding each qualifying facility a share of the pool based on the ratio of its Medicaid days to the total Medicaid days for all the qualifying facilities.

(e) Award Criteria

The following criteria will be applied to facility data up to March 31 each year to determine eligibility for the award to be presented in May. In order to be eligible for the award, a facility must participate in the Vermont Medicaid program and meet all of the following criteria. All eligible facilities will be ranked according to their quality of care by the Department of Disabilities, Aging and Independent Living based on these basic quality criteria. The five facilities with the highest quality of care will receive an award. If, based on the basic criteria, there are ties which would cause more than five facilities to be equally qualified, the tied facilities will be ranked according to the efficiency criteria set out below in paragraph (6), to determine those facilities that will receive an award.

(1) The most recent health survey report resulted in a score of five or less, no deficiency with a scope and severity greater than "D" level, with no more than two "D" level deficiencies in the general categories of Quality of Care, Quality of Life, or Resident Rights.

(2) No substantiated complaints since the most recent survey and prior full health survey related to quality of care, quality of life, or residents' rights.

(3) Participation in Advancing Excellence in America's Nursing Homes campaign.

(4) Resident satisfaction survey results above the statewide average.

(5) Fire Safety deficiency score of 5 or less with scope and severity less than "E" in the most recent full survey.

(6) The efficiency rankings shall be based upon the allowable costs per day from each facility's most recently settled Medicaid cost report. Cost per day will be calculated using actual resident days for the same fiscal period.

## 10 EXTRAORDINARY FINANCIAL RELIEF

### 10.1 Objective

In order to protect Medicaid recipients from the closing of a nursing facility in which they reside, this section establishes a process by which nursing homes that are in immediate danger of failure may seek extraordinary financial relief. This process does not create any entitlement to rates in excess of those required by 33 V.S.A. Chapter 9 or to any other form of relief.

### 10.2 Nature of the Relief

(a) Based on the individual circumstances of each case, the Director may recommend any of the following on such financial, managerial, quality, operational or other conditions as she or he shall find appropriate: a rate adjustment, an advance of Medicaid payments, other relief appropriate to the circumstances of the applicant, or no relief.

(b) The Director's Recommendation shall be in writing and shall state the reasons for the Recommendation. The Recommendation shall be a public record.

(c) The Recommendation shall be reviewed by the Secretary who shall make a Final Decision, which shall not be subject to administrative or judicial review.

(d) In those cases where the Division determines that financial relief may be appropriate, such relief may be implemented on an interim basis pending a Final Decision by the Secretary. The interim financial relief shall be taken into account in the Division's Recommendation to the Secretary and in the Secretary's Final Decision.

### 10.3 Criteria to be Considered by the Division

(a) Before a provider may apply for extraordinary financial relief, its financial condition must be such that there is a substantial likelihood that it will be unable to continue in existence in the immediate future.

(b) The following factors will be considered by the Director in making the Recommendation to the Secretary:

(1) the likelihood of the facility's closing without financial assistance,

(2) the inability of the applicant to pay bona fide debts,

(3) the potential availability of funds from related parties, parent corporations, or any other source,

(4) the ability to borrow funds on reasonable terms,

(5) the existence of payments or transfers for less than adequate consideration,

(6) the extent to which the applicant's financial distress is beyond the applicant's control,

(7) the extent to which the applicant can demonstrate that assistance would prevent, not merely postpone the closing of the facility,

(8) the extent to which the applicant's financial distress has been caused by a related party or organization,

(9) the quality of care provided at the facility,

(10) the continuing need for the facility's beds,

(11) the age and condition of the facility,

(12) other factors found by the Director to be material to the particular circumstances of the facility, and

(13) the ratio of individuals receiving care in a nursing facility to individuals receiving home- and community-based services in the county in which the facility is located.

**10.4 Procedure for Application**

(a) An Application for Extraordinary Financial Relief shall be filed with the Division according to procedures to be prescribed by the Director.

(b) The Application shall be in writing and shall be accompanied by such documentation and proofs as the Director may prescribe. The burden of proof is at all times on the provider. If the materials filed by the provider are inadequate to serve as a basis for a reasoned recommendation, the Division shall deny the Application, unless additional proofs are submitted.

(c) The ~~Secretary~~ Commissioner shall not be bound in considering other Applications by any prior decision made on any Application under this section. Such decisions shall have no precedential value either for the applicant facility or for any other facility.

## 11 PAYMENT FOR OUT-OF-STATE PROVIDERS

**11.1 Long-Term Care Facilities Other Than Rehabilitation Centers**

Payment for services, other than Rehabilitation Center services, provided to Vermont Medicaid residents in long-term care facilities in another state shall be at the per diem rate established for Medicaid payment by the appropriate agency in that state. Payment of the per diem rate shall constitute full and final payment, and no retroactive settlements will be made.

**11.2 Rehabilitation Centers**

(a) Payment for prior-authorized Rehabilitation Center services provided in nursing facilities located outside Vermont for the severely disabled, such as head injured or ventilator dependent people, will be made at the lowest of:

(1) the amount charged; or

(2) the Medicaid rate, including ancillaries as paid by at least one other state agency in CMS Region I.

(b) Payment for Rehabilitation Center services which have not been prior authorized by the Commissioner of the Department of Vermont Health Access or a designee will be made according to Subsection 11.1.

**11.3 Pediatric Care**

No Medicaid payments will be made for services provided to Vermont pediatric residents in out-of-state long-term care facilities without the prior authorization of the Commissioner of the Department of Vermont Health Access.

## 12 RATES FOR ICF/MRS

**12.1 Reasonable Cost Reimbursement**

Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are paid according to Medicaid principles of reimbursement, pursuant to the *Regulations Governing the Operation of Intermediate Care Facilities for the Mentally Retarded* adopted by the Agency.

**12.2 Application of these Rules to ICF/MRS**

The Division's Accounting Requirements (Section 2) and Financial Reporting (Section 3) shall apply to this program.

## 13 RATES FOR SWING BEDS AND OTHER LONG-TERM CARE SERVICES IN HOSPITALS

Payment for swing-bed and other long-term care services provided by hospitals, pursuant to 42 U.S.C. §1396l(a), shall be made at a rate equal to the average rate per diem during the previous calendar year under the State Plan to nursing facilities located in the State of Vermont. Supplemental payments made pursuant to section 14 and subsection 9.5 shall not be included in the calculation of swing-bed rates.

## 14 SPECIAL RATES FOR CERTAIN INDIVIDUAL RESIDENTS

### 14.1 Availability of Special Rates for Individuals with Unique Physical Conditions

(a) In rare and exceptional circumstances, a special rate shall be available for the care of an individual eligible for the Vermont Medicaid program whose unique physical conditions makes it otherwise extremely difficult to obtain appropriate long-term care.

(b) A special rate under this subsection is available subject to the conditions set out below.

(c) Required Findings. Before a rate is payable under this section:

(1) the Commissioner of the Department of Vermont Health Access, in consultation with the Department's Medical Director, and the Director of Adult Services Division, must make a written finding that the individual's care needs meet the requirements of this section and that the proposed placement is appropriate for that individual's needs; and

(2) the Division of Rate Setting, in consultation with the Commissioner of the Department of Vermont Health Access and the Commissioner of the Department of Disabilities, Aging and Independent Living, must determine that the special rate, calculated pursuant to paragraph (e) of this subsection, is reasonable for the services provided.

(d) Plan of Care:

(1) Before an individual can be placed with any facility and a rate established, pursuant to this subsection, a plan of care for that person must be approved by the Director of Adult Services Division and the Medical Director of the Department of Vermont Health Access.

(2) The facility shall submit the resident's assessment and plan of care for review by the Director of Adult Services Division and the Medical Director of the Department of Vermont Health Access whenever there is a significant change in the resident's condition, but in no case less frequently than every six months. This review shall form the basis for a determination that the payment of the special rate should be continued or revised pursuant to 14.1(e)(2).

(e) Calculation of the Special Rate:

(1) A per diem rate shall be set by the Division based on the budgeted allowable costs for the individual's plan of care. The rate shall be exempt from the limits in section 7 of these rules.

(2) From time to time the special rate may be revised to reflect significant changes in the resident's assessment, care plan, and costs of providing care. The Division may adjust the special rate retroactively based on the actual allowable costs of providing care to the resident.

(3) Special rates set under this section shall not affect the facility's normal per diem rate. The case-mix weight of any resident on whose behalf a special rate is paid shall not be included in the calculation of the facility's average case-mix score pursuant to subsection 7.2(b), but the days of care shall be included in the facility's Medicaid

days and total resident days. The provider shall track the total costs of providing care to the resident and shall self-disallow the incremental cost of such care on cost reports covering the period during which the facility receives Medicaid payments for services to the resident.

### 14.2 Special Rates for Certain Former Patients of the Vermont State Hospital

(a) A special rate is available for nursing home services to patients transferred directly from the Vermont State Hospital or to such other similarly situated individuals as the Commissioner of Mental Health shall approve. The rate shall be prospective and shall be set before admission of the individual to the facility.

(1) The special rate payable for each individual shall consist of the current per diem rate for the receiving facility as calculated pursuant to Sections 5 to 9 of these rules and a monthly supplemental incentive payment. Three levels of supplemental payments are available for the care of residents meeting the eligibility criteria in this subsection based on the severity of the resident's condition and the resources needed to provide care.

(2) The supplemental payment will continue to be paid as long as the criteria in paragraph (c) are satisfied.

(b) To be eligible for a special rate, the receiving facility must have in place a plan of care developed in conjunction with and approved by the Commissioner of Mental Health and the Division of Licensing and Protection.

(c) Criteria for continuation of supplemental payments:

(i) The transferred person continues to reside at the receiving facility.

(ii) The facility documents to the satisfaction of the Division of Licensing and Protection that the transferred person continues to present significant behavior management problems by exhibiting behaviors that are significantly more challenging than those of the general nursing facility population.

(d) Any advance payments for days during which the transferred person is not resident or ceases to be eligible for the special transitional rate will be treated as overpayments and subject to refund by deductions from the provider's Medicaid payments.

### 14.3 Special Rates for Medicaid Eligible Furloughees of the Department of Corrections

A special rate equal to 150 percent of a nursing facility's ordinary Medicaid rate shall be paid for care provided to Medicaid eligible furloughees of the Department of Corrections.

## 15 ADMINISTRATIVE REVIEW AND APPEALS

### 15.1 Draft Findings and Decisions

(a) Before issuing findings on any Desk Review, Audit of a Cost Report, or decision on any application for a rate adjustment, the Division shall serve a draft of such findings or decision on the affected provider. If the Division makes no adjustment to a facility's reported costs or application for a rate adjustment, the Division's findings shall be final and shall not be subject to appeal under this section.

(b) The provider shall review the draft upon receipt. If it desires to review the Division's work papers, it shall file, within 10 days, a written Request for Work Papers on a form prescribed by the Director.

### 15.2 Request for an Informal Conference on Draft Findings and Decisions

(a) Within 15 days of receipt of either the draft findings or decision or requested work papers, whichever is the later, a provider that is dissatisfied with the draft findings or decision issued pursuant to Subsection 15.1(a) may file a written Request for an Informal Conference with the Division's staff on a form prescribed by the Director.

(b) Within 10 days of the receipt of the Request, the Division shall contact the provider to arrange a mutually convenient time for the informal conference, which shall be held within 45 days of the receipt of the Request at the Division. The informal conference may be held by telephone. At the conference, if necessary, a date certain shall be fixed by which the provider may file written submissions or other additional necessary information. Within 20 days thereafter, the Division shall issue its official agency action.

(c) A Request for an Informal Conference must be pursued before a Request for Reconsideration can be filed pursuant to Subsection 15.3. Issues not raised in the Request for Informal Conference shall not be raised at the informal conference or in any subsequent proceeding arising from the same action of the Division, including appeals pursuant to 33 V.S.A. §909.

(d) Should no timely Request for an Informal Conference be filed within the time period specified in Subsection 15.2(a), the Division's draft findings and/or decision are final and no longer subject to administrative review or judicial appeal.

### 15.3 Request for Reconsideration

(a) A provider that is aggrieved by an official action issued pursuant to Subsection 15.2(b) may file a Request for Reconsideration.

(b) A Request for Reconsideration must be pursued before an appeal can be taken pursuant to 33 V.S.A. 909(a).

(c) The Request for Reconsideration must be in writing, on a form prescribed by the Director, and filed within 30 days of the provider's receipt of the official action.

(d) Within 10 days of the filing of a Request for Reconsideration, the provider must file the following:

(1) A request for a hearing, if desired;

(2) A clear statement of the alleged errors in the Division's action and of the remedy requested including: a description of the facts on which the Request is based, a memorandum stating the support for the requested relief in this rule, CMS-15, or other authority for the requested relief and the rationale for the requested remedy; and

(3) If no hearing is requested, evidence necessary to bear the provider's burden of proof, including, if applicable, a proposed revision of the Division's calculations, with supporting work papers.

(e) Issues not raised in the Request for Reconsideration shall not be raised later in this proceeding or in any subsequent proceeding arising from the same action of the Division, including appeals pursuant to 33 V.S.A. §909.

(f) If a hearing is requested, within 10 days of the receipt of the Request for Reconsideration, the Division shall contact the provider to arrange a mutually agreeable time.

(g) The hearing shall be conducted by the Director or her or his designee. The testimony shall be under oath and shall be recorded either stenographically or on tape. If the provider so requests, the Division staff involved in the official action appealed shall appear and testify. The Director, or her or his designee, may hold the record open to a date certain for the receipt of additional materials.

(h) The Director shall issue a Final Order on Request for Reconsideration no later than 30 days after the record closes. Pending the

issuance of a final order, the official action issued pursuant to subsection 15.2(b) shall be used as the basis for setting an interim rate from the first day of the calendar quarter following its issuance. Final orders shall be effective from the effective date of the official action.

(i) Proceedings under this section are not subject to the requirements of 3 V.S.A. Chapter 25.

**15.4 Appeals from Final Orders of the Division**

(a) Within 30 days of the date thereof, a nursing facility aggrieved by a Final Order of the Division may file an appeal pursuant to 33 V.S.A. §909(a) and Subsections 15.5, 15.6 and 15.7 of this rule.

(b) Within 30 days of the date thereof, a ICF/MR aggrieved by a Final Order of the Division may file an appeal using the following procedures. Proceedings under this paragraph are not subject to the requirements of 3 V.S.A. Chapter 25.

(1) Request for Administrative Review by the Commissioner of Mental Health. The Commissioner or a designee shall review a final order of the Division of Rate Setting if a timely request is filed with the Director of the Division.

(i) Within 10 days of the receipt of the Request, the Director shall forward to the Commissioner a copy of the Request for Administrative Review and the materials that represent the documentary record of the Division's action.

(ii) The Commissioner or the designee shall review the record of the appeal and may request such additional materials as they shall deem appropriate, and shall, if requested by the provider, convene a hearing on no less than 10 days written notice to the provider and the Division. Within 45 days after the close of the record, the Commissioner or the designee shall issue a decision which shall be served on the provider and the Division.

(2) Appeal to the Secretary of Human Services. Within 20 days of the date of the date of issuance, an ICF/MR aggrieved by the Commissioner's decision, may appeal to the Secretary.

(i) The Notice of Appeal shall be filed with the Commissioner, who, within 10 days of the receipt of the Notice, shall forward to the Secretary a copy of the Notice and the record of the Administrative Review.

(ii) The Secretary or his designee shall review the record of the Administrative Review and may, within their sole discretion, hold a hearing, request more documentary information, or take such other steps to review the Commissioner's decision as shall seem appropriate.

(iii) Within 60 days of the filing of the Notice of Appeal or the closing of the record, whichever is the later, the Secretary or the designee shall issue a Final Determination.

(3) Further review of the Final Determination is available only pursuant to Rule 75 of the Vermont Rules of Civil Procedure.

**15.5 Request for Administrative Review to the Secretary of Human Services pursuant to 33 V.S.A. §909(a)(3)**

(a) No appeal may be taken under this section when the remedy requested is retrospective relief from the operation of a provision of this rule or such other relief as may be outside the power of the Secretary to order. Such relief may be pursued by an appeal to the Vermont Supreme Court or Superior

Court pursuant to 33 V.S.A. §909(a)(1) and (2), or prospectively by a request for rulemaking pursuant 3 V.S.A. §806.

(b) Appeals under this section shall be governed by the relevant provisions of the Administrative Procedures Act, 3 V.S.A. §§809-815.

(c) Proceedings under this section shall be initiated by filing two copies of a written Request for Administrative Review with the Division, on forms prescribed therefor.

(d) Within 5 days of receipt of the Request, the Director shall forward one copy to the Secretary. Within 10 days thereafter, the Secretary shall designate an independent appeals officer who shall be a registered or certified public accountant. The Letter of Designation shall be served on all parties to the appeal. All documents filed thereafter shall be filed directly with the independent appeals officer and copies served on all parties.

(e) Within 10 days of the designation of an independent appeals officer, the Division shall forward to him or her those materials that represent the documentary record of the Division's action.

(f) Within 30 days thereafter, the independent appeals officer shall, on reasonable notice to the parties, convene a prehearing conference (which may be held by telephone) to consider such matters as may aid in the efficient disposition of the case, including but not limited to:

(1) the simplification of the issues,

(2) the possibility of obtaining stipulations of fact and/or admissions of documents which will avoid unnecessary proof,

(3) the appropriateness of prefiled testimony,

(4) a schedule for the future conduct of the case.

The independent appeals officer shall make an order which recites the action taken at the conference, including any agreements made by the parties.

(g) The independent appeals officer shall hold a hearing, pursuant to 3 V.S.A. §809, on no less than 10 days written notice to the parties, according to the schedule determined at the prehearing conference. The independent appeals officer shall have the power to subpoena witnesses and documents and administer oaths. Testimony shall be under oath and shall be recorded either stenographically or on tape. Prefiled testimony, if admitted into evidence, shall be included in the transcript, if any, as though given orally at the hearing. Evidentiary matters shall be governed by 3 V.S.A. §810.

(h) The independent appeals officer may allow or require each party to file Proposed Findings of Fact which shall contain a citation to the specific part or parts of the record containing the evidence upon which the proposed finding is based. The Proposed Findings shall be accompanied by a Memorandum of Law which shall address each matter at issue.

(i) Within 60 days after the date of the hearing, or after the filing of Proposed Findings of Fact, whichever is the later, the independent appeals officer shall file with the Secretary a Recommendation for Decision, a copy of which shall be served on each of the parties. The Recommendation for Decision shall include numbered findings of fact and conclusions of law, separately stated, and a proposed order. If a party has submitted Proposed Findings of Fact, the Recommendation for Decision shall include a ruling upon each proposed finding. Each party's Proposed Findings and Memorandum of Law shall accompany the Recommendation.

(j) At the time the independent appeals officer makes her or his Recommendation, she or he shall transmit the docket file to the Secretary. The Secretary shall retain the file

for a period of at least one year from the date of the Final Determination in the docket. In the event of an appeal of the Secretary's Final Determination to the Vermont Supreme Court or to Superior Court, the Secretary shall make disposition of the file as required by the applicable rules of civil and appellate procedure.

(k) Any party aggrieved by the Recommendation for Decision may file Exceptions, Briefs, and if desired, a written Request for Oral Argument before the Secretary. These submissions shall be filed with the Secretary within 15 days of the date of the receipt of a copy of the Recommendation and copies served on all other parties.

(l) If oral argument is requested, within 20 days of the receipt of the Request for Oral Argument, the Secretary shall arrange with the parties a mutually convenient time for a hearing.

(m) Within 45 days of the receipt of the Recommendation or the hearing on oral argument, whichever is the later, the Secretary shall issue a Final Determination which shall be served on the parties.

(n) A party aggrieved by a Final Determination of the Secretary may obtain judicial review pursuant to 33 V.S.A. §909(a)(1) and (2) and Subsections 15.6 and 15.7 of this Rule.

### 15.6 Appeal to Vermont Supreme Court pursuant to 33 V.S.A. §909(a)(1)

Proceedings under this section shall be initiated, pursuant to the Vermont Rules of Appellate Procedure, as follows:

(a) by filing a Notice of Appeal from a Final Order with the Division; or

(b) by filing a Notice of Appeal from a Final Determination with the Secretary.

### 15.7 Appeal to Superior Court pursuant to 33 V.S.A. §909(a)(2)

De novo review is available in the Superior Court of the county where the nursing facility is located. Such proceedings shall be initiated, pursuant to Rule 74 of the Vermont Rules of Civil Procedure, as follows:

(a) by filing a Notice of Appeal from a Final Order with the Division; or

(b) by filing a Notice of Appeal from a Final Determination with the Secretary.

### 15.8 Settlement Agreements

The Director may agree to settle reviews and appeals taken pursuant to Subsections 15.3 and 15.5, and, with the approval of the Secretary, may agree to settle other appeals taken pursuant to 33 V.S.A. §909 and any other litigation involving the Division on such reasonable terms as she or he may deem appropriate to the circumstances of the case.

## 16 DEFINITIONS AND TERMS

For the purposes of these rules the following definitions and terms are used:

**Accrual Basis of Accounting:** an accounting system in which revenues are reported in the period in which they are earned, regardless of when they are collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

**Agency:** the Agency of Human Services.

**AICPA:** American Institute of Certified Public Accountants.

**Allowable Costs or Expenses:** costs or expenses that are recognized as reasonable and related to resident care in accordance with these rules.

**Base Year:** a calendar year for which the allowable costs are the basis for the case-mix prospective per diem rate.

**Case-Mix Weight:** a relative evaluation of the nursing resources used in the care of a given class of residents.

**Centers for Medicare and Medicaid Services(CMS)** (formerly called the Health Care Financing Administration (HCFA)): Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.

**Certificate of Need (CON):** certificate of approval for a new institutional health service, issued pursuant to 18 V.S.A. §2403.

**Certified Rate:** the rate certified by the Division of Rate Setting to the Department of Vermont Health Access.

**Common Control:** where an individual or organization has the power to influence or direct the actions or policies of both a provider and an organization or institution serving the provider, or to influence or direct the transactions between a provider and an organization serving the provider. The term includes direct or indirect control, whether or not it is legally enforceable.

**Common Ownership:** where an individual or organization owns or has equity in both a facility and an institution or organization providing services to the facility.

**Companion Aide:** a Licensed Nurse Aide (LNA) with specialized training in person-centered dementia care.

**Cost Finding:** the process of segregating direct costs by cost centers and allocating indirect costs to determine the cost of services provided.

**Cost Report:** a report prepared by a provider on forms prescribed by the Division.

**Direct Costs:** costs which are directly identifiable with a specific activity, service or product of the program.

**Director:** the Director of Rate Setting.

**Division:** the Division of Rate Setting, Agency of Human Services.

**Donated Asset:** an asset acquired without making any payment in the form of cash, property or services.

**Facility or nursing facility:** a nursing home facility licensed and certified for participation in the Medicaid Program by the State of Vermont.

**Fair Market Value:** the price an asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.

**FASB:** Financial Accounting Standards Board.

**Final Order of the Division:** an action of the Division which is not subject to change by the Division, for which no review or appeal is available from the Division, or for which the review or appeal period has passed.

**Free standing facility:** a facility that is not hospital-affiliated.

**Funded Depreciation:** funds that are restricted by a facility's governing body for purposes of acquiring assets to be used in rendering resident care or servicing long term debt.

**Fringe Benefits:** shall include payroll taxes, workers' compensation, pension, group health, dental and life insurances, profit sharing, cafeteria plans and flexible spending plans, child care for employees, employee parties, and gifts shared by all staff. Fringe benefits may include tuition for college credit in a discipline related to the individual staff

member's employment or costs of obtaining a GED.

**Generally Accepted Accounting Principles (GAAP):** those accounting principles with substantial authoritative support. In order of authority the following documents are considered GAAP: (1) FASB Standards and Interpretations, (2) APB Opinions and Interpretations, (3) CAP Accounting Research Bulletins, (4) AICPA Statements of Position, (5) AICPA Industry Accounting and Auditing Guides, (6) FASB Technical Bulletins, (7) FASB Concepts Statements, (8) AICPA Issues Papers and Practice Bulletins, and other pronouncements of the AICPA or FASB.

**Generally Accepted Auditing Standards (GAAS):** the auditing standards that are most widely recognized in the public accounting profession.

**Health Care Cost Service:** publication, by Global Insight, Inc., of national forecasts of hospital, nursing home (NHMB), and home health agency market baskets and regional forecasts of CPI (All Urban) for food and commercial power and CPIU-All Items.

**Hold Day:** a day for which the provider is paid to hold a bed open is counted as a resident day.

**Hospital-affiliated facility:** a facility that is a distinct part of a hospital provider, located either at the hospital site or within a reasonable proximity to the hospital.

**Incremental Cost:** the added cost incurred in alternative choices.

**Independent Public Accountant:** a Certified Public Accountant or Registered Public Accountant not employed by the provider.

**Indirect Costs:** costs which cannot be directly identified with a particular activity, service or product of the program. Indirect costs are apportioned among the program's services using a rational statistical basis.

**Inflation Factor:** a factor that takes into account the actual or projected rate of inflation or deflation as expressed in indicators such as the New England Consumer Price Index.

**Interim Rate:** a prospective Case-Mix rate paid to nursing facilities on a temporary basis.

**Look-back:** a review of a facility's actual costs for a previous period prescribed by the Division.

**Medicaid Resident:** a nursing home resident for whom the primary payor for room and board is the Medicaid program.

**New England Consumer Price Index (NECPI-U):** the New England consumer price index for all urban consumers as published by the Health Care Cost Service.

**New Health Care Project:** A project requiring a certificate of need (CON) pursuant to 18 V.S.A.§9434(a) or projects which would require a CON except that their costs are lower than those required for CON jurisdiction pursuant 18 V.S.A.§ 9434(a).

**OBRA 1987:** the Omnibus Budget Reconciliation Act of 1987.

**Occupancy Level:** the number of paid days, including hold days, as a percentage of the licensed bed capacity.

**Paid feeding/dining assistants:** persons (other than the facility's administrator, registered nurses, licensed practical nurses, certified or licensed nurse aides) who are qualified under state law pursuant to 42 C.F.R. §§483.35(h)(2), 483.160 and 488.301 and who are paid to assist in the feeding of residents.

**Per Diem Cost:** the cost for one day of resident care.

**Prescription Drugs:** drugs for which a physician's prescription is required by state or federal law.

**Person-Centered Dementia Care:** care that includes the following elements: an individualized approach to care planning that uses the perspective of the person with dementia as the primary frame of reference; values the personhood of the individual with dementia; and provides a social environment that supports psychological needs.

**Prospective Case-Mix Reimbursement System:** a method of paying health care providers rates that are established in advance. These rates take into account the fact that some residents are more costly to care for than others.

**Provider Reimbursement Manual, CMS-15:** a manual published by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, used by the Medicare Program to determine allowable costs.

**Rate year:** the State's fiscal year ending June 30.

**Related organization or related party**: an individual or entity that is directly or indirectly under common ownership or control or is related by family or other business association with the provider. Related organizations include but are not restricted to entities in which an individual who directly or indirectly receives or expects to receive compensation in any form is also an owner, partner, officer, director, key employee, or lender, with respect to the provider, or is related by family to such persons.

**Resident Assessment Form:** Vermont version of a federal form, which captures data on a resident's condition and which is used to predict the resource use level needed to care for the resident.

**Resident Day:** any day of services for which the facility is paid. For example, a paid hold day is counted as a resident day.

**Restricted Funds and Revenue:** funds and investment income earned from funds restricted for specific purposes by donors, excluding funds restricted or designated by an organization's governing body.

**RUG IV:** A systematic classification of residents in nursing facilities based upon a broad study of nursing care time required by groups of residents exhibiting similar needs.

**Secretary:** the Secretary of the Agency of Human Services.

**Special hospital-based nursing facility:** a facility that meets the following criteria: (a) is physically integrated as part of a hospital building with at least one common wall and a direct internal access between the hospital and the nursing home; (b) is part of a single corporation that governs both the hospital and the nursing facility; and (c) files one Medicare cost report for both the hospital and the nursing home.

**Standardized Resident Days:** Base Year resident days multiplied by the facility's average Case-Mix score for the base year.

**State nursing facilities:** facilities owned and/or operated by the State of Vermont.

**Swing-Bed:** a hospital bed used to provide nursing facility services.

## 17 TRANSITIONAL PROVISIONS

Notwithstanding any other provisions of these rules, the amendments to these rules effective March 6, 2015 shall be applied to payments for services rendered on or after March 1, 2015.

## 17.1 Companion Aide Pilot Project

The Companion Aide Pilot Project will provide a per diem rate adjustment to selected facilities to develop additional knowledge and experience in the area of person-centered dementia care through the use of Companion Aides. Companion Aides will be Licensed Nurse Aides with specialized training in person-centered dementia care to provide an individualized approach that uses the perspective of the person with dementia as the primary frame of reference.

The work of the Companion Aides funded by this pilot program must comply with the job description detailed in the Companion Aide application. The selected nursing facilities may have the Companion Aide work any shift.

The pilot project will be for 2.5 years beginning January 1, 2015 and ending on June 30, 2017.

(a) Selection Process

(1) All Vermont nursing facilities participating in the Medicaid program are eligible to apply.

(2) Five facilities will be selected from the pool of completed applications by the Commissioner of the Department of Disabilities Aging and Independent Living. One facility will be selected from each of five geographical areas of the State based on the county groupings in the Council on Aging service areas. These geographical areas will be Northwest Vermont (Addison, Chittenden, Franklin and Grand Isle counties); Northeast Vermont (Caledonia, Essex, and Orleans counties); Central Vermont (Lamoille, Orange, and Washington counties); Southwest Vermont (Rutland and Bennington counties); and Southeast Vermont (Windham and Windsor counties).

(3) Within each geographical area, the applicants will be ranked by the proportion of their residents with a diagnosis of Alzheimer's or dementia compared to the number of total residents, and the facility with the highest proportion will be selected. This data will be reported on the Companion Aide application and must be from the Minimum Data Set (MDS) information used for the June 15, 2014 picture date in the second quarter of 2014.

(4) If no nursing facility applies from a given region, an additional nursing facility from the geographical area with the highest number of applicants will be selected. If there are two regions with no applicants, an additional facility then will be selected from the geographical area with the second highest number of applicants.

(5) If there is a tie in the selection process, the facility with the highest percentage of Medicaid residents to total residents for State fiscal year 2014, based on census information reported to the Division of Rate Setting, will be selected.

(b) Rate Adjustment Calculations and Procedures

(1) The rate adjustment will include the salary and fringe benefit costs for the approved number of Companion Aides at the selected facilities. The hourly salaries and fringe benefit rates will be reported on the Companion Aide application and reviewed by the Division of Rate Setting.

(2) The selected facilities will be funded at a ratio of five Companion Aides per 100 filled beds. The calculated number shall be rounded up or down to determine the number of Companion Aide Full Time Equivalents (2,080 hours/year). The resulting number of aides to be funded will vary with the number of filled beds at the selected facilities.

(3) The number of total beds filled shall equal the total number of residents reported

on the June 15, 2014 MDS picture date (Q2 2014) summary report supplied to the Division of Licensing and Protection.

(c) Inflation of Rate Adjustments

The original per diem adjustment for Companion Aides will be inflated on July 1, 2015 and July 1, 2016 using the same methodology as detailed in Subsection 5.8 of these rules.

(d) End of Adjustment and Special Nursing Rebase Provisions

(1) The adjustments in this Section will be terminated as of July 1, 2017 when Nursing Care costs are rebased to base year 2015. This will be the first year when the costs of the Companion Aides will be in the facility's base year costs.

(2) For facilities with years ending earlier than December 31, the Division will annualize the cost of the Companion Aides so that a full year of these costs will be included in the selected facilities' 2015 base year costs.

(3) The Companion Aide costs at the five selected facilities will be exempt from the cap on nursing costs in the July 1, 2017 rebase. In rebases after that time, the extant cap on Nursing Care Costs will apply.

(e) Ongoing Reporting Requirements

The selected facilities shall complete an annual Companion Aide Pilot Project Outcome Report. This report will be sent to the providers with the Companion Aide application so nursing facility staff will understand the data reporting requirement when they apply for the pilot. These reports will be due by November 10, 2015 and November 10, 2016. The Division may end the Companion Aide rate adjustment for a facility that does not comply with the ongoing reporting requirements.

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 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; 2021, No. 20, § 281.)

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 that 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. § 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. 85. An act relating to extending COVID-19 health care regulatory flexibility.**

(H.654)

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. 2020 Acts and Resolves No. 91, as amended by 2020 Acts and Resolves No. 140, Sec. 13, 2020 Acts and Resolves No. 159, Sec. 10, 2021 Acts and Resolves No. 6, Secs. 1 and 3, and 2021 Acts and Resolves No. 69, Sec. 19, is further amended to read:

* * * Supporting Health Care and Human Service Provider Sustainability * * *

Sec. 1. AGENCY OF HUMAN SERVICES; HEALTH CARE AND HUMAN SERVICE PROVIDER SUSTAINABILITY

Through March 31, ~~2022~~ 2023, the Agency of Human Services shall consider 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 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.

* * *

* * * 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, through March 31, ~~2022~~ 2023, 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 State and federal public health 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, through March 31, ~~2022~~ 2023, 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

(a) 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~~ through March 31, 2023, 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.

(b) As part of any proceeding conducted on or after February 1, 2022 to establish or enforce a hospital's fiscal year 2022 or 2023 budget, the Green Mountain Care Board shall consider the hospital's extraordinary labor costs and investments, as well as the impacts of those costs and investments on the affordability of health care.

Sec. 6. MEDICAID AND HEALTH INSURERS; PROVIDER ENROLLMENT AND CREDENTIALING

Until March 31, ~~2022~~ 2023, and 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. 8. ACCESS TO HEALTH CARE SERVICES; DEPARTMENT OF FINANCIAL REGULATION; EMERGENCY RULEMAKING

(a) It is the intent of the General Assembly to increase Vermonters' access to medically necessary health care services during and after a declared state of emergency in Vermont as a result of COVID-19.

(b)(1) Until April 1, ~~2022~~ 2023, and notwithstanding any provision of 3 V.S.A. § 844 to the contrary, the Department of Financial Regulation shall consider adopting, and shall have the authority to adopt, emergency rules to address the following through March 31, ~~2022~~ 2023:

(A) expanding health insurance coverage for, and waiving or limiting cost-sharing requirements directly related to, the diagnosis of COVID-19, including tests for influenza, pneumonia, and other respiratory viruses

performed in connection with making a COVID-19 diagnosis; the treatment of COVID-19 when it is the primary or a secondary diagnosis; and the prevention of COVID-19; and

(B) 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.

(2) Any rules adopted in accordance with this subsection shall remain in effect until not later than April 1, ~~2022~~ 2023.

* * * Access to Health Care Services and Human 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) Through March 31, ~~2022~~ 2023, 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. 12. BUPRENORPHINE; PRESCRIPTION RENEWALS

Through March 31, ~~2022~~ 2023, 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

Through March 31, ~~2022~~ 2023, 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. 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, through March 31, ~~2022~~ 2023, 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;~~ as a volunteer member of the Medical Reserve Corps~~;~~ or, for a period not to exceed six months, as part of the staff of a licensed facility, other health care facility as defined in 18 V.S.A. § 9432, or federally qualified health center, 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 a volunteer member of the Medical Reserve Corps or as part of the staff of a licensed facility, other health care facility as defined in 18 V.S.A. § 9432, or federally qualified health center 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)(1) This section shall remain in effect through March 31, ~~2022~~ 2023, provided the health care professional remains licensed, certified, or registered in good standing throughout the period the health care professional is practicing in Vermont, which shall not exceed six months for a health care professional providing health care services as part of the staff of a licensed facility, other health care facility as defined in 18 V.S.A. § 9432, or federally qualified health center.

(2) The Board of Medical Practice and Office of Professional Regulation shall provide appropriate notice of the March 31, ~~2022~~ 2023 expiration date of this section to:

(A) health care professionals providing health care services in Vermont under this section;

(B) the Medical Reserve Corps; and

(C) health care facilities and federally qualified health centers at which health care professionals are providing services under this section.

(e) Nothing in this section is intended to limit, restrict, or modify the application of existing or future federal waivers of health care professional licensure requirements to licensed and certified facilities.

Sec. 18. INACTIVE LICENSEES; BOARD OF MEDICAL PRACTICE; OFFICE OF PROFESSIONAL REGULATION

(a)(1) Through March 31, ~~2022~~ 2023, a former health care professional, including a mental health professional, whose Vermont license, certificate, or registration became inactive not more than three years earlier and was in good standing at the time it became inactive may provide health care services, including mental health services, to a patient located in Vermont using telehealth; as a volunteer member of the Medical Reserve Corps; or as part of the staff of a licensed facility, other health care facility as defined in 18 V.S.A. § 9432, or federally qualified health center 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.

(3) The Board of Medical Practice and Office of Professional Regulation shall provide appropriate notice of the March 31, ~~2022~~ 2023 expiration date of this section to:

(A) health care professionals providing health care services under this section;

(B) the Medical Reserve Corps; and

(C) health care facilities and federally qualified health centers at which health care professionals are providing services under this section.

(b) Through March 31, ~~2022~~ 2023, the Board of Medical Practice and the Office of Professional Regulation may permit former health care professionals, including mental health professionals, whose Vermont license, certificate, or registration became inactive more than three but less than 10 years earlier and was in good standing at the time it became inactive 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. 20. OFFICE OF PROFESSIONAL REGULATION; BOARD OF MEDICAL PRACTICE; EMERGENCY AUTHORITY TO ACT FOR REGULATORY BOARDS

(a)(1) Through March 31, ~~2022~~ 2023, 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) Through March 31, ~~2022~~ 2023, 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

Through March 31, ~~2022~~ 2023, 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.

* * *

* * * Telehealth * * *

* * *

Sec. 26. WAIVER OF CERTAIN TELEHEALTH REQUIREMENTS FOR A LIMITED TIME

~~(a)~~ Notwithstanding any provision of 8 V.S.A. § 4100k or 18 V.S.A. § 9361 to the contrary, through March 31, ~~2022~~ 2023, 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 or guidance regarding enforcement discretion:

(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; and

(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.

~~(b) Notwithstanding any provision of 8 V.S.A. § 4100k or 18 V.S.A. § 9361 to the contrary, until 60 days following a declared state of emergency in Vermont as a result of COVID-19, a health care provider shall not be required~~

~~to obtain and document 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. 2. 2020 Acts and Resolves No. 140, Sec. 15, as amended by 2021 Acts and Resolves No. 6, Sec. 2, is further amended to read:

Sec. 15. BOARD OF MEDICAL PRACTICE; TEMPORARY PROVISIONS; PHYSICIANS, PHYSICIAN ASSISTANTS, AND PODIATRISTS

(a) Notwithstanding any provision of 26 V.S.A. § 1353(11) to the contrary, the Board of Medical Practice or its Executive Director may issue a temporary license through March 31, ~~2022~~ 2023 to an individual who is 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 a date not later than April 1, ~~2022~~ 2023, provided the licensee remains in good standing.

(b) Through March 31, ~~2022~~ 2023, the Board of Medical Practice or its Executive Director may waive requirements for physician assistants, including scope of practice requirements and the requirement for documentation of the relationship between a physician assistant and a physician pursuant to

26 V.S.A. § 1735a. The Board or Executive Director may impose limitations or conditions when granting a waiver under this subsection.

Sec. 3. 2020 Acts and Resolves No. 178, Sec. 12a, as amended by 2021 Acts and Resolves No. 6, Sec. 2a, is further amended to read:

Sec. 12a. SUNSET OF PHARMACIST AUTHORITY TO ORDER OR ADMINISTER SARS-COV TESTS

In Sec. 11, 26 V.S.A. § 2023(b)(2)(A)(x) (clinical pharmacy prescribing; State protocol; SARS-CoV testing) shall be repealed on March 31, ~~2022~~ 2023.

Sec. 4. 2021 Acts and Resolves No. 6, Sec. 8 is amended to read:

Sec. 8. TELEPHONE TRIAGE SERVICES; DEPARTMENT OF FINANCIAL REGULATION; EMERGENCY RULEMAKING

Notwithstanding any provision of 3 V.S.A. § 844 to the contrary, the Department of Financial Regulation shall consider adopting, and shall have the authority to adopt, emergency rules to address health insurance coverage of and reimbursement for telephone calls used to determine whether an office visit or other service is needed. Emergency rules adopted pursuant to this section shall remain in effect until not later than April 1, ~~2022~~ 2023.

Sec. 5. OFFICE OF PROFESSIONAL REGULATION; BOARD OF MEDICAL PRACTICE; OUT-OF-STATE HEALTH CARE PROFESSIONALS THROUGH MARCH 31, 2022

(a) Notwithstanding any provision of Vermont's professional licensure statutes or rules to the contrary, through March 31, 2022, a health care

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 to a patient located in Vermont using telehealth, 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 delivers health care services to a patient located in Vermont using telehealth 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.

(c) This section shall remain in effect through March 31, 2022, provided the health care professional remains licensed, certified, or registered in good standing. Beginning on April 1, 2022 and continuing through June 30, 2023, an out-of-state health care professional shall register with the Office of Professional Regulation or Board of Medical Practice, as applicable, in

accordance with Sec. 6 of this act in order to provide or to continue to provide health care services to one or more patients located in Vermont.

Sec. 6. TEMPORARY TELEHEALTH REGISTRATION FOR OUT-OF-STATE HEALTH CARE PROFESSIONALS

Notwithstanding any provision of Vermont's professional licensure statutes or rules to the contrary, from the period from April 1, 2022 through June 30, 2023, the Office of Professional Regulation and Board of Medical Practice shall register a health care professional who is not licensed or registered to practice in Vermont but who seeks to provide health care services to patients or clients located in Vermont using telehealth, provided:

(1) the health care professional completes an application in the manner specified by the Director of the Office of Professional Regulation or the Board of Medical Practice, as applicable; and

(2)(A) the health care professional holds an active, unencumbered license, certificate, or registration in at least one other U.S. jurisdiction to practice the health care profession for which the health care professional seeks to provide telehealth services in Vermont;

(B) the health care professional's license, certificate, or registration is in good standing in all other U.S. jurisdictions in which the health care professional is licensed, certified, or registered to practice; and

(C) the health care professional provides verification of licensure, certification, or registration to the Office or the Board, as applicable.

Sec. 7. 18 V.S.A. § 9721 is amended to read:

§ 9721. ADVANCE DIRECTIVES; COVID-19 ~~STATE OF EMERGENCY~~; REMOTE WITNESSES AND EXPLAINERS

* * *

(c)(1) Notwithstanding any provision of subsection 9703(b) of this title to the contrary, an advance directive executed by a principal between June 15, 2020 and ~~June 30, 2022~~ March 31, 2023 shall be deemed to be valid even if the principal signed the advance directive outside the physical presence of one or both of the required witnesses, provided all of the following conditions are met with respect to each remote witness:

* * *

(d)(1) Notwithstanding any provision of subsection 9703(d) or (e) of this title to the contrary, an advance directive executed by a principal between February 15, 2020 and ~~June 30, 2022~~ March 31, 2023 while the principal was being admitted to or was a resident of a nursing home or residential care facility or was being admitted to or was a patient in a hospital shall be deemed to be valid even if the individual who explained the nature and effect of the advance directive to the principal in accordance with subsection 9703(d) or (e) of this title, as applicable, was not physically present in the same location as the principal at the time of the explanation, provided the individual delivering the explanation was communicating with the principal by video or telephone.

(2) An advance directive executed in accordance with this subsection shall remain valid as set forth in subsection (b) or (c) of this section, as applicable.

Sec. 8. EFFECTIVE DATE

This act shall take effect on passage.

Date Governor signed bill: March 22, 2022

**No. 83. An act relating to fiscal year 2022 budget adjustments.**

(H.679)

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. 2021 Acts and Resolves No. 74, Sec. B.126 is amended to read:

Sec. B.126 Legislature

| | | |
|---|---|---|
| Personal services | ~~5,033,474~~ | 5,138,474 |
| Operating expenses | 3,768,163 | 3,768,163 |
| Total | ~~8,801,637~~ | 8,906,637 |
| Source of funds | | |
| General fund | ~~8,801,637~~ | 8,906,637 |
| Total | ~~8,801,637~~ | 8,906,637 |

Sec. 2. 2021 Acts and Resolves No. 74, Sec. B.127 is amended to read:

Sec. B.127 Joint fiscal committee

| | | |
|---|---|---|
| Personal services | ~~2,288,387~~ | 2,478,387 |
| Operating expenses | 158,873 | 158,873 |
| Total | ~~2,447,260~~ | 2,637,260 |
| Source of funds | | |
| General fund | ~~2,322,260~~ | 2,512,260 |
| Interdepartmental transfers | 125,000 | 125,000 |
| Total | ~~2,447,260~~ | 2,637,260 |

Sec. 3. 2021 Acts and Resolves No. 74, Sec. B.145 is amended to read:

Sec. B.145 Total general government

| | | |
|---|---|---|
| Source of funds | | |
| General fund | ~~98,982,912~~ | 99,277,912 |
| Transportation fund | 3,911,594 | 3,911,594 |
| Special funds | 16,446,601 | 16,446,601 |
| Federal funds | 1,150,041 | 1,150,041 |
| Internal service funds | 138,310,838 | 138,310,838 |
| Interdepartmental transfers | 7,551,641 | 7,551,641 |
| Enterprise funds | 6,840 | 6,840 |
| Pension trust funds | 7,169,079 | 7,169,079 |
| Private purpose trust funds | 1,135,286 | 1,135,286 |
| Total | ~~274,664,832~~ | 274,959,832 |

Sec. 4. 2021 Acts and Resolves No. 74, Sec. B.225.2 is amended to read:

Sec. B.225.2 Agriculture, Food and Markets - Clean Water

| | | |
|---|---|---|
| Personal services | 3,249,011 | 3,249,011 |
| Operating expenses | 486,344 | 486,344 |
| Grants | ~~4,060,891~~ | 5,503,348 |
| Total | ~~7,796,246~~ | 9,238,703 |
| Source of funds | | |
| General fund | 1,087,080 | 1,087,080 |
| Special funds | ~~6,089,920~~ | 7,532,377 |

| | | |
|---|---|---|
| Federal funds | 133,534 | 133,534 |
| Interdepartmental transfers | 485,712 | 485,712 |
| Total | ~~7,796,246~~ | 9,238,703 |

Sec. 5. 2021 Acts and Resolves No. 74, Sec. B.240 is amended to read:

Sec. B.240 Cannabis Control Board

| | | |
|---|---|---|
| Personal services | ~~650,000~~ | 850,000 |
| Total | ~~650,000~~ | 850,000 |

Source of funds

| | | |
|---|---|---|
| Special funds | ~~650,000~~ | 850,000 |
| Total | ~~650,000~~ | 850,000 |

Sec. 6. 2021 Acts and Resolves No. 74, Sec. B.241 is amended to read:

Sec. B.241 Total protection to persons and property

Source of funds

| | | |
|---|---|---|
| General fund | 171,360,524 | 171,360,524 |
| Transportation fund | 20,250,000 | 20,250,000 |
| Special funds | ~~91,319,879~~ | 92,962,336 |
| Tobacco fund | 561,843 | 561,843 |
| Federal funds | 70,315,412 | 70,315,412 |
| ARRA funds | 520,000 | 520,000 |
| Interdepartmental transfers | 14,457,347 | 14,457,347 |
| Enterprise funds | 12,785,618 | 12,785,618 |
| Total | ~~381,570,623~~ | 383,213,080 |

Sec. 7. 2021 Acts and Resolves No. 74, Sec. B.300 is amended to read:

Sec. B.300 Human services - agency of human services - secretary's office

| | | |
|---|---|---|
| Personal services | ~~11,427,819~~ | 11,346,910 |
| Operating expenses | 5,214,621 | 5,214,621 |
| Grants | 2,895,202 | 2,895,202 |
| Total | ~~19,537,642~~ | 19,456,733 |
| Source of funds | | |
| General fund | ~~8,430,401~~ | 8,802,492 |
| Special funds | 135,517 | 135,517 |
| Federal funds | 9,959,398 | 9,959,398 |
| Global Commitment fund | ~~453,000~~ | 0 |
| Interdepartmental transfers | 559,326 | 559,326 |
| Total | ~~19,537,642~~ | 19,456,733 |

Sec. 8. 2021 Acts and Resolves No. 74, Sec. B.301 is amended to read:

Sec. B.301 Secretary's office - global commitment

| | | |
|---|---|---|
| Grants | ~~1,680,637,999~~ | 1,839,201,185 |
| Total | ~~1,680,637,999~~ | 1,839,201,185 |
| Source of funds | | |
| General fund | ~~559,592,034~~ | 585,702,238 |
| Special funds | ~~33,370,086~~ | 33,228,937 |
| Tobacco fund | 21,049,373 | 21,049,373 |
| State health care resources fund | ~~17,078,501~~ | 16,023,501 |

| | | |
|---|---|---|
| Federal funds | ~~1,044,929,568~~ | 1,179,162,966 |
| Interdepartmental transfers | ~~4,618,437~~ | 4,034,170 |
| Total | ~~1,680,637,999~~ | 1,839,201,185 |

Sec. 9. 2021 Acts and Resolves No. 74, Sec. B.306 is amended to read:

Sec. B.306 Department of Vermont health access - administration

| | | |
|---|---|---|
| Personal services | ~~130,163,425~~ | 130,170,447 |
| Operating expenses | ~~26,394,423~~ | 26,444,423 |
| Grants | ~~3,192,301~~ | 2,912,301 |
| Total | ~~159,750,149~~ | 159,527,171 |

Source of funds

| | | |
|---|---|---|
| General fund | ~~32,776,219~~ | 33,116,885 |
| Special funds | ~~3,363,758~~ | 5,678,861 |
| Federal funds | ~~114,469,002~~ | 111,590,255 |
| Global Commitment fund | 4,314,039 | 4,314,039 |
| Interdepartmental transfers | 4,827,131 | 4,827,131 |
| Total | ~~159,750,149~~ | 159,527,171 |

Sec. 10. 2021 Acts and Resolves No. 74, Sec. B.307 is amended to read:

Sec. B.307 Department of Vermont health access - Medicaid program global commitment

| | | |
|---|---|---|
| Personal services | 547,983 | 547,983 |
| Grants | ~~757,772,233~~ | 855,581,847 |
| Total | ~~758,320,216~~ | 856,129,830 |

Source of funds

| | | |
|---|---|---|
| Global Commitment fund | ~~758,320,216~~ | 856,129,830 |
| Total | ~~758,320,216~~ | 856,129,830 |

Sec. 11. 2021 Acts and Resolves No. 74, Sec. B.309 is amended to read:

Sec. B.309 Department of Vermont health access - Medicaid program - state only

| | | |
|---|---|---|
| Grants | ~~42,367,754~~ | 50,029,823 |
| Total | ~~42,367,754~~ | 50,029,823 |

Source of funds

| | | |
|---|---|---|
| General fund | ~~42,315,703~~ | 40,459,853 |
| Global Commitment fund | ~~52,051~~ | 9,569,970 |
| Total | ~~42,367,754~~ | 50,029,823 |

Sec. 12. 2021 Acts and Resolves No. 74, Sec. B.310 is amended to read:

Sec. B.310 Department of Vermont health access - Medicaid non-waiver matched

| | | |
|---|---|---|
| Grants | ~~32,842,006~~ | 34,768,604 |
| Total | ~~32,842,006~~ | 34,768,604 |

Source of funds

| | | |
|---|---|---|
| General fund | ~~12,664,602~~ | 12,817,789 |
| Federal funds | ~~20,177,404~~ | 21,950,815 |
| Total | ~~32,842,006~~ | 34,768,604 |

Sec. 13. 2021 Acts and Resolves No. 74, Sec. B.311 is amended to read:

Sec. B.311 Health - administration and support

| | | |
|---|---|---|
| Personal services | 5,753,602 | 5,753,602 |
| Operating expenses | ~~6,567,686~~ | 5,946,041 |
| Grants | 6,313,608 | 6,313,608 |
| Total | ~~18,634,896~~ | 18,013,251 |
| Source of funds | | |
| General fund | ~~2,982,217~~ | 2,360,572 |
| Special funds | 2,061,857 | 2,061,857 |
| Federal funds | 7,777,658 | 7,777,658 |
| Global Commitment fund | 5,748,858 | 5,748,858 |
| Interdepartmental transfers | 64,306 | 64,306 |
| Total | ~~18,634,896~~ | 18,013,251 |

Sec. 14. 2021 Acts and Resolves No. 74, Sec. B.314 is amended to read:

Sec. B.314 Mental health - mental health

| | | |
|---|---|---|
| Personal services | ~~32,985,332~~ | 34,712,990 |
| Operating expenses | ~~4,700,264~~ | 4,850,264 |
| Grants | ~~246,498,959~~ | 234,392,478 |
| Total | ~~284,184,555~~ | 273,955,732 |
| Source of funds | | |
| General fund | ~~10,281,092~~ | 10,850,067 |
| Special funds | 1,685,284 | 1,685,284 |

| | | |
|---|---|---|
| Federal funds | ~~9,398,134~~ | 9,377,108 |
| Global Commitment fund | ~~262,745,408~~ | 251,968,636 |
| Interdepartmental transfers | 74,637 | 74,637 |
| Total | ~~284,184,555~~ | 273,955,732 |

Sec. 15. 2021 Acts and Resolves No. 74, Sec. B.316 is amended to read:

Sec. B.316 Department for children and families - administration & support services

| | | |
|---|---|---|
| Personal services | ~~38,362,798~~ | 39,823,024 |
| Operating expenses | ~~17,035,520~~ | 19,109,020 |
| Grants | 3,819,106 | 3,819,106 |
| Total | ~~59,217,424~~ | 62,751,150 |
| Source of funds | | |
| General fund | ~~33,091,620~~ | 34,739,860 |
| Special funds | ~~2,711,682~~ | 2,761,682 |
| Federal funds | ~~21,062,298~~ | 23,494,784 |
| Global Commitment fund | ~~2,000,936~~ | 1,403,936 |
| Interdepartmental transfers | 350,888 | 350,888 |
| Total | ~~59,217,424~~ | 62,751,150 |

Sec. 16. 2021 Acts and Resolves No. 74, Sec. B.317 is amended to read:

Sec. B.317 Department for children and families - family services

| | | |
|---|---|---|
| Personal services | ~~39,332,995~~ | 39,636,555 |
| Operating expenses | 4,997,338 | 4,997,338 |

| | | |
|---|---|---|
| Grants | ~~81,171,012~~ | 83,187,102 |
| Total | ~~125,501,345~~ | 127,820,995 |
| Source of funds | | |
| General fund | ~~49,047,462~~ | 49,543,086 |
| Special funds | 729,587 | 729,587 |
| Federal funds | ~~31,365,138~~ | 32,373,091 |
| Global Commitment fund | ~~44,344,158~~ | 45,137,731 |
| Interdepartmental transfers | ~~15,000~~ | 37,500 |
| Total | ~~125,501,345~~ | 127,820,995 |

Sec. 17. 2021 Acts and Resolves No. 74, Sec. B.318 is amended to read:

Sec. B.318 Department for children and families - child development

| | | |
|---|---|---|
| Personal services | ~~5,020,429~~ | 5,624,306 |
| Operating expenses | ~~848,079~~ | 921,579 |
| Grants | ~~100,111,841~~ | 97,958,128 |
| Total | ~~105,980,349~~ | 104,504,013 |
| Source of funds | | |
| General fund | ~~27,348,614~~ | 25,996,178 |
| Special funds | 16,820,000 | 16,820,000 |
| Federal funds | ~~50,874,814~~ | 50,623,626 |
| Global Commitment fund | ~~10,914,421~~ | 11,064,209 |
| Interdepartmental transfers | ~~22,500~~ | 0 |
| Total | ~~105,980,349~~ | 104,504,013 |

Sec. 18. 2021 Acts and Resolves No. 74, Sec. B.321 is amended to read:

Sec. B.321 Department for children and families - general assistance

| | | |
|---|---|---|
| Personal services | 15,000 | 15,000 |
| Grants | 2,823,574 | 2,823,574 |
| Total | 2,838,574 | 2,838,574 |
| Source of funds | | |
| General fund | ~~2,441,239~~ | 2,541,239 |
| Federal funds | ~~111,320~~ | 11,320 |
| Global Commitment fund | 286,015 | 286,015 |
| Total | 2,838,574 | 2,838,574 |

Sec. 19. 2021 Acts and Resolves No. 74, Sec. B.323 is amended to read:

Sec. B.323 Department for children and families - reach up

| | | |
|---|---|---|
| Operating expenses | 29,119 | 29,119 |
| Grants | 31,842,843 | 31,842,843 |
| Total | 31,871,962 | 31,871,962 |
| Source of funds | | |
| General fund | ~~19,904,694~~ | 19,704,694 |
| Special funds | ~~5,854,320~~ | 5,954,320 |
| Federal funds | ~~3,431,330~~ | 3,531,330 |
| Global Commitment fund | 2,681,618 | 2,681,618 |
| Total | 31,871,962 | 31,871,962 |

Sec. 20. 2021 Acts and Resolves No. 74, Sec. B.325 is amended to read:

Sec. B.325 Department for children and families - office of economic opportunity

| | | |
|---|---|---|
| Personal services | 636,177 | 636,177 |
| Operating expenses | 43,488 | 43,488 |
| Grants | ~~19,383,262~~ | 25,483,262 |
| Total | ~~20,062,927~~ | 26,162,927 |
| Source of funds | | |
| General fund | ~~14,225,798~~ | 20,325,798 |
| Special funds | 57,990 | 57,990 |
| Federal funds | 4,423,154 | 4,423,154 |
| Global Commitment fund | 1,355,985 | 1,355,985 |
| Total | ~~20,062,927~~ | 26,162,927 |

Sec. 21. 2021 Acts and Resolves No. 74, Sec. B.327 is amended to read:

Sec. B.327 Department for Children and Families - Secure Residential Treatment

| | | |
|---|---|---|
| Personal services | 258,100 | 258,100 |
| Operating expenses | 650,463 | 650,463 |
| Grants | ~~3,476,862~~ | 3,773,834 |
| Total | ~~4,385,425~~ | 4,682,397 |
| Source of funds | | |
| General fund | ~~4,355,425~~ | 4,652,397 |

| | | |
|---|---|---|
| Global Commitment fund | 30,000 | 30,000 |
| Total | ~~4,385,425~~ | 4,682,397 |

Sec. 22. 2021 Acts and Resolves No. 74, Sec. B.328 is amended to read:

Sec. B.328 Department for children and families - disability determination services

| | | |
|---|---|---|
| Personal services | ~~7,139,139~~ | 6,991,600 |
| Operating expenses | 460,858 | 460,858 |
| Total | ~~7,599,997~~ | 7,452,458 |
| Source of funds | | |
| General fund | 111,120 | 111,120 |
| Federal funds | ~~7,488,877~~ | 7,341,338 |
| Total | ~~7,599,997~~ | 7,452,458 |

Sec. 23. 2021 Acts and Resolves No. 74, Sec. B.329 is amended to read:

Sec. B.329 Disabilities, aging, and independent living - administration & support

| | | |
|---|---|---|
| Personal services | ~~33,906,585~~ | 35,498,760 |
| Operating expenses | 5,953,426 | 5,953,426 |
| Total | ~~39,860,011~~ | 41,452,186 |
| Source of funds | | |
| General fund | ~~17,731,954~~ | 19,174,129 |
| Special funds | 1,390,457 | 1,390,457 |
| Federal funds | ~~19,671,316~~ | 19,821,316 |

| | | |
|---|---|---|
| Interdepartmental transfers | 1,066,284 | 1,066,284 |
| Total | ~~39,860,011~~ | 41,452,186 |

Sec. 24. 2021 Acts and Resolves No. 74, Sec. B.330 is amended to read:

Sec. B.330 Disabilities, aging, and independent living - advocacy and independent living grants

| | | |
|---|---|---|
| Grants | ~~19,352,893~~ | 19,921,075 |
| Total | ~~19,352,893~~ | 19,921,075 |
| Source of funds | | |
| General fund | 7,644,654 | 7,644,654 |
| Federal funds | 7,148,466 | 7,148,466 |
| Global Commitment fund | ~~4,559,773~~ | 5,127,955 |
| Total | ~~19,352,893~~ | 19,921,075 |

Sec. 25. 2021 Acts and Resolves No. 74, Sec. B.334 is amended to read:

Sec. B.334 Disabilities, aging, and independent living - Brain injury home and community based waiver

| | | |
|---|---|---|
| Grants | ~~5,564,689~~ | 5,714,689 |
| Total | ~~5,564,689~~ | 5,714,689 |
| Source of funds | | |
| Global Commitment fund | ~~5,564,689~~ | 5,714,689 |
| Total | ~~5,564,689~~ | 5,714,689 |

Sec. 26. 2021 Acts and Resolves No. 74, Sec. B.334.1 is amended to read:

Sec. B.334.1 Disabilities, aging and independent living - Long Term Care

| | | |
|---|---|---|
| Grants | ~~230,505,916~~ | 238,018,868 |
| Total | ~~230,505,916~~ | 238,018,868 |
| Source of funds | | |
| General fund | 498,579 | 498,579 |
| Federal funds | 2,083,333 | 2,083,333 |
| Global Commitment fund | ~~227,924,004~~ | 235,436,956 |
| Total | ~~230,505,916~~ | 238,018,868 |

Sec. 27. 2021 Acts and Resolves No. 74, Sec. B.339 is amended to read:

Sec. B.339 Corrections - Correctional services-out of state beds

| | | |
|---|---|---|
| Personal services | ~~5,640,604~~ | 5,223,574 |
| Total | ~~5,640,604~~ | 5,223,574 |
| Source of funds | | |
| General fund | ~~5,640,604~~ | 5,223,574 |
| Total | ~~5,640,604~~ | 5,223,574 |

Sec. 28. 2021 Acts and Resolves No. 74, Sec. B.342 is amended to read:

Sec. B.342 Vermont veterans' home - care and support services

| | | |
|---|---|---|
| Personal services | ~~19,020,560~~ | 20,520,560 |
| Operating expenses | ~~5,426,960~~ | 5,899,095 |
| Total | ~~24,447,520~~ | 26,419,655 |

Source of funds

| | | |
|---|---|---|
| General fund | ~~2,843,321~~ | 4,025,456 |
| Special funds | ~~11,868,942~~ | 12,658,942 |
| Federal funds | 9,735,257 | 9,735,257 |
| Total | ~~24,447,520~~ | 26,419,655 |

Sec. 29. 2021 Acts and Resolves No. 74, Sec. B.346 is amended to read:

Sec. B.346 Total human services

Source of funds

| | | |
|---|---|---|
| General fund | ~~1,022,527,917~~ | 1,056,891,225 |
| Special funds | ~~116,659,874~~ | 119,773,828 |
| Tobacco fund | 23,088,208 | 23,088,208 |
| State health care resources fund | ~~17,078,501~~ | 16,023,501 |
| Federal Coronavirus Relief Fund | 15,000,000 | 15,000,000 |
| Federal funds | ~~1,497,837,906~~ | 1,634,136,654 |
| Global Commitment fund | ~~1,641,496,441~~ | 1,746,171,697 |
| Internal service funds | 1,951,982 | 1,951,982 |
| Interdepartmental transfers | ~~25,329,631~~ | 24,745,364 |
| Permanent trust funds | 25,000 | 25,000 |
| Total | ~~4,360,995,460~~ | 4,637,807,459 |

Sec. 30. [Deleted.]

Sec. 31. 2021 Acts and Resolves No. 74, Sec. B.400 is amended to read:

Sec. B.400 Labor - programs

| | | |
|---|---|---|
| Personal services | ~~31,359,103~~ | 30,259,103 |
| Operating expenses | 7,701,210 | 7,701,210 |
| Grants | 1,822,409 | 1,822,409 |
| Total | ~~40,882,722~~ | 39,782,722 |
| Source of funds | | |
| General fund | 5,394,154 | 5,394,154 |
| Special funds | 6,422,539 | 6,422,539 |
| Federal funds | ~~28,658,417~~ | 27,558,417 |
| Interdepartmental transfers | 407,612 | 407,612 |
| Total | ~~40,882,722~~ | 39,782,722 |

Sec. 32. 2021 Acts and Resolves No. 74, Sec. B.401 is amended to read:

Sec. B.401 Total labor

| | | |
|---|---|---|
| Source of funds | | |
| General fund | 5,394,154 | 5,394,154 |
| Special funds | 6,422,539 | 6,422,539 |
| Federal funds | ~~28,658,417~~ | 27,558,417 |
| Interdepartmental transfers | 407,612 | 407,612 |
| Total | ~~40,882,722~~ | 39,782,722 |

Sec. 33. [Deleted.]

Sec. 34. [Deleted.]

Sec. 35. 2021 Acts and Resolves No. 74, Sec. B.605 is amended to read:

Sec. B.605 Vermont student assistance corporation

| | | |
|---|---|---|
| Grants | ~~22,251,315~~ | 19,978,588 |
| Total | ~~22,251,315~~ | 19,978,588 |
| Source of funds | | |
| General fund | 19,978,588 | 19,978,588 |
| Interdepartmental transfers | ~~2,272,727~~ | 0 |
| Total | ~~22,251,315~~ | 19,978,588 |

Sec. 36. 2021 Acts and Resolves No. 74, Sec. B.608 is amended to read:

Sec. B.608 Total higher education

| | | |
|---|---|---|
| Source of funds | | |
| General fund | 98,861,685 | 98,861,685 |
| Education fund | 41,225 | 41,225 |
| Global Commitment fund | 409,461 | 409,461 |
| Interdepartmental transfers | ~~2,272,727~~ | 0 |
| Total | ~~101,585,098~~ | 99,312,371 |

Sec. 37. 2021 Acts and Resolves No. 74, Sec. B.702 is amended to read:

Sec. B.702 Fish and wildlife - support and field services

| | | |
|---|---|---|
| Personal services | ~~18,654,752~~ | 18,754,752 |
| Operating expenses | ~~6,717,480~~ | 7,617,480 |
| Grants | 670,446 | 670,446 |
| Total | ~~26,042,678~~ | 27,042,678 |

| | | |
|---|---|---|
| Source of funds | | |
| General fund | 6,403,816 | 6,403,816 |
| Special funds | ~~239,657~~ | 1,239,657 |
| Fish and wildlife fund | 9,561,364 | 9,561,364 |
| Federal funds | 8,504,410 | 8,504,410 |
| Interdepartmental transfers | 1,322,431 | 1,322,431 |
| Permanent trust funds | 11,000 | 11,000 |
| Total | ~~26,042,678~~ | 27,042,678 |

Sec. 38. 2021 Acts and Resolves No. 74, Sec. B.711 is amended to read:

Sec. B.711 Environmental conservation - office of water programs

| | | |
|---|---|---|
| Personal services | 28,652,311 | 28,652,311 |
| Operating expenses | 6,722,953 | 6,722,953 |
| Grants | ~~31,819,350~~ | 29,319,350 |
| Total | ~~67,194,614~~ | 64,694,614 |
| Source of funds | | |
| General fund | 7,926,170 | 7,926,170 |
| Special funds | ~~22,601,929~~ | 20,101,929 |
| Federal funds | 36,003,082 | 36,003,082 |
| Interdepartmental transfers | 663,433 | 663,433 |
| Total | ~~67,194,614~~ | 64,694,614 |

Sec. 39. 2021 Acts and Resolves No. 74, Sec. B.713 is amended to read:

Sec. B.713 Natural resources board

| | | |
|---|---|---|
| Personal services | ~~2,597,208~~ | 2,747,096 |
| Operating expenses | ~~545,630~~ | 395,742 |
| Total | 3,142,838 | 3,142,838 |
| Source of funds | | |
| General fund | 631,629 | 631,629 |
| Special funds | 2,511,209 | 2,511,209 |
| Total | 3,142,838 | 3,142,838 |

Sec. 40. 2021 Acts and Resolves No. 74, Sec. B.714 is amended to read:

Sec. B.714 Total natural resources

| | | |
|---|---|---|
| Source of funds | | |
| General fund | 31,693,115 | 31,693,115 |
| Special funds | ~~78,151,968~~ | 76,651,968 |
| Fish and wildlife fund | 9,561,364 | 9,561,364 |
| Federal funds | 54,981,735 | 54,981,735 |
| Interdepartmental transfers | 11,534,344 | 11,534,344 |
| Permanent trust funds | 11,000 | 11,000 |
| Total | ~~185,933,526~~ | 184,433,526 |

Sec. 41. 2021 Acts and Resolves No. 74, Sec. B.900 is amended to read:

Sec. B.900 Transportation - finance and administration

| | | |
|---|---|---|
| Personal services | ~~13,654,880~~ | 13,558,021 |

| | | |
|---|---|---|
| Operating expenses | 2,507,103 | 2,507,103 |
| Grants | 50,000 | 50,000 |
| Total | ~~16,211,983~~ | 16,115,124 |
| Source of funds | | |
| Transportation fund | ~~15,815,083~~ | 15,718,224 |
| Federal funds | 396,900 | 396,900 |
| Total | ~~16,211,983~~ | 16,115,124 |

Sec. 42. 2021 Acts and Resolves No. 74, Sec. B.903 is amended to read:

Sec. B.903 Transportation - program development

| | | |
|---|---|---|
| Personal services | ~~58,611,534~~ | 58,092,913 |
| Operating expenses | ~~227,109,245~~ | 226,965,577 |
| Grants | 28,813,660 | 28,813,660 |
| Total | ~~314,534,439~~ | 313,872,150 |
| Source of funds | | |
| Transportation fund | ~~48,717,849~~ | 48,055,560 |
| TIB fund | 10,597,637 | 10,597,637 |
| Federal funds | 254,737,875 | 254,737,875 |
| Local match | 481,078 | 481,078 |
| Total | ~~314,534,439~~ | 313,872,150 |

Sec. 43. 2021 Acts and Resolves No. 74, Sec. B.905 is amended to read:

Sec. B.905 Transportation - maintenance state system

| | | |
|---|---|---|
| Personal services | ~~45,339,790~~ | 45,955,270 |

| | | |
|---|---|---|
| Operating expenses | ~~57,902,709~~ | 58,046,377 |
| Grants | 277,000 | 277,000 |
| Total | ~~103,519,499~~ | 104,278,647 |
| Source of funds | | |
| Transportation fund | ~~87,191,712~~ | 87,950,860 |
| Federal funds | 16,227,787 | 16,227,787 |
| Interdepartmental transfers | 100,000 | 100,000 |
| Total | ~~103,519,499~~ | 104,278,647 |

Sec. 44. 2021 Acts and Resolves No. 74, Sec. B.919 is amended to read:

Sec. B.919 Transportation - municipal mitigation assistance program

| | | |
|---|---|---|
| Operating expenses | 265,000 | 265,000 |
| Grants | ~~5,845,000~~ | 8,020,150 |
| Total | ~~6,110,000~~ | 8,285,150 |
| Source of funds | | |
| Transportation fund | 705,000 | 705,000 |
| Special funds | ~~3,977,000~~ | 6,152,150 |
| Federal funds | 1,428,000 | 1,428,000 |
| Total | ~~6,110,000~~ | 8,285,150 |

Sec. 45. 2021 Acts and Resolves No. 74, Sec. B.922 is amended to read:

Sec. B.922 Total transportation

| | | |
|---|---|---|
| Source of funds | | |
| Transportation fund | 271,865,668 | 271,865,668 |

| | | |
|---|---|---|
| TIB fund | 11,397,637 | 11,397,637 |
| Special funds | ~~4,027,000~~ | 6,202,150 |
| Federal funds | 361,546,034 | 361,546,034 |
| Internal service funds | 22,202,720 | 22,202,720 |
| Interdepartmental transfers | 2,888,052 | 2,888,052 |
| Local match | 1,833,316 | 1,833,316 |
| Total | ~~675,760,427~~ | 677,935,577 |

Sec. 46. 2021 Acts and Resolves No. 74, Sec. B.1106 is amended to read:

Sec. B.1106 FISCAL YEAR 2022 ONE-TIME GENERAL FUND APPROPRIATIONS

(a) In fiscal year 2022, funds are appropriated from the General Fund for new and ongoing initiatives as follows:

(1) ~~$38,430,000~~ $39,460,000 to the Agency of Administration for the following:

(A) ~~$11,580,000~~ $12,420,000 for distribution to departments to fund the fiscal year 2022 53rd week of Medicaid.

(B) ~~$12,450,000~~ $12,640,000 for distribution to departments to fund the fiscal year 2022 27th payroll pay period.

* * *

(12) $126,000 to the ~~Agency of Human Services Secretary's Office~~ Department for Children and Families – administration and support services to maintain the 211-call center.

* * *

(21) $25,000,000 to the Agency of Human Services – Central Office to address emergent and exigent circumstances following the COVID-19 pandemic.

(A) On or before March 1, 2022, the Agency of Human Services shall report to the House and Senate Committees on Appropriations on a plan to address costs associated with contract staffing for nursing homes. The plan shall include a methodology for addressing costs incurred for State fiscal year 2022, as well as a timeline for implementation. The plan shall include a timeline to address the rate setting process for future ongoing base costs starting in State fiscal year 2023.

(B) Funds appropriated in the subsection may be included among the Global Commitment appropriations referenced in 2021 Acts and Resolves No. 74, Sec. E.301.2 as available for transfers if it is determined that grants made under this provision can be included and matched in the Global Commitment waiver.

(22) $3,300,000 to the Agency of Digital Services for a cybersecurity initiative as follows:

(A) $2,300,000 for purchase and implementation of Security Information and Event Management software.

(B) $1,000,000 to prepay the fiscal year 2023 annual licensing/maintenance costs for the system.

(23) $350,000 to the Department of Environmental Conservation to evaluate and provide an analysis of the capital and ongoing operations and maintenance costs of the Green River Dam. Any unspent funds shall be directed to State-owned dams to evaluate the capital and ongoing operations and maintenance costs.

(24) $33,000 to the Joint Fiscal Office for the expense of a consultant for the Health Reform Oversight Committee.

(25) $350,000 to the Agency of Education to provide support for the four statewide nonprofit organizations in the Adult Education and Literacy (AEL) network to address budget shortfalls resulting from the effects of COVID-19.

(26) $300,000 to the Public Service Department to support the continuity of statewide public, educational, and governmental (PEG) access services.

(27) $166,667 to the Department of Health, Public Health, to support four statewide syringe services programs.

(28) $250,000 to the Agency of Commerce and Community Development, Housing and Community Development, to make grants to municipal planning organizations.

(29) $112,000 to the Center for Crime Victim Services for legal services for victims.

(30) $50,000 to the Agency of Education for the vaccine incentive program at the four historical academies of Burr and Burton Academy, Lyndon Institute, St. Johnsbury Academy, and Thetford Academy that are not eligible to receive Elementary and Secondary School Emergency Relief (ESSER) funds.

(31) $150,000 to the Agency of Commerce and Community Development for a grant to the Town of New Haven for expenses related to the relocation of the railroad station. These funds are in addition to other funding provided to the town for the same purpose from other State entities and other sources.

(32) $500,000 to the Green Mountain Care Board for a consultant to perform per capita benchmarking analyses with comparisons to national, peers, and better performers. This shall include an analysis of avoidable utilization and low value care.

(33) $500,000 to the Agency of Commerce and Community Development to provide state match for the Build to Scale proposal to be submitted to the U.S. Economic Development Administration for federal funding.

Sec. 47. FISCAL YEAR 2022; VERMONT STATE EMPLOYEES' RETIREMENT SYSTEM; RECOMMENDATIONS; DEPARTMENT OF CORRECTIONS EMPLOYEES; LONGEVITY INCENTIVE

(a) On or before April 15, 2022, the State Treasurer and the Board of Trustees for the Vermont State Employees Retirement System shall recommend to the House and Senate Committees on Appropriations and on Government Operations a plan for the following:

(1) the creation of a new pension benefit group for Department of Corrections employees that is actuarially neutral to the pension system and results in no additional employer pension costs; and

(2) the development of a longevity incentive that encourages Group F members who are eligible for a normal retirement a longevity incentive to continue working past their retirement date, provided that the incentive is designed to result in actuarial savings to the pension system and reduce employer pension expenses.

Sec. 48. 2021 Acts and Resolves No. 74, Sec. D.101 is amended to read:

Sec. D.101 FUND TRANSFERS, REVERSIONS AND RESERVES

(a) Notwithstanding any other provision of law, the following amounts are transferred from the funds indicated:

* * *

(6) From the Clean Water Fund (21932) established by 10 V.S.A. § 1388 to the Agricultural Water Quality Special Fund (21933) created under 6 V.S.A. § 4803: ~~$4,521,393~~ $5,963,850.

* * *

(9) From the Transportation Infrastructure Bond Fund established by 19 V.S.A. § 11f to the Transportation Infrastructure Bonds Debt Service Fund (35200) established by 32 V.S.A. § 951a for funding ~~fiscal year 2023 transportation infrastructure bonds debt service~~ the redemption of transportation infrastructure bonds prior to maturity: $2,502,363.

(10) From the Transportation FHWA Fund (20135) to the Transportation Infrastructure Bonds Debt Service Fund (35200) established by 32 V.S.A. § 951a for funding the redemption of transportation infrastructure bonds prior to maturity: $12,554,768.

(11) From the Transportation Fund – Non-Dedicated (20105) to the Transportation Infrastructure Bonds Debt Service Fund (35200) established by 32 V.S.A. § 951a for funding the redemption of transportation infrastructure bonds prior to maturity: $4,863,957.

(12) From the General Fund to the Property Management Fund (58700) established by 29 V.S.A. § 160: $5,000,000.

(13) From the General Fund to the State Liability Self-Insurance Fund (56200): $5,000,000.

(14) From the General Fund to the Victims Compensation Special Fund (21145) established by 13 V.S.A. § 5359: $1,300,000.

(15) From the General Fund to the Domestic and Sexual Violence Special Fund (21926) established by 13 V.S.A. § 5360: $250,000.

(b) Notwithstanding any provisions of law to the contrary, in fiscal year 2022:

(1) The following amounts shall be transferred to the General Fund from the funds indicated:

* * *

| | | |
|---|---|---|
| 21500 | Interdepartmental Transfer Fund – 7100000022 | $125,000.00 |

* * *

(d) Notwithstanding any provision of law to the contrary, in fiscal year 2022, the following amounts shall revert to the General Fund from the accounts indicated:

| | | |
|---|---|---|
| 2150010000 | Military – administration | ~~$200,000.00~~ $316,556.00 |
| 1210002000 | Legislature | ~~$140,000.00~~ $435,000.00 |
| 1215001000 | Legislative Counsel | $50,000.00 |
| 1220000000 | Joint Fiscal Office | $50,000.00 |
| 1225001000 | Legislative IT | $60,000.00 |
| 1100010000 | Secretary of Administration | $50,000.00 |
| 1110003000 | Budget & Management | $117,075.64 |
| 1110006000 | University of Vermont | $1.00 |
| 1110007000 | UVM– Morgan Horse Farm | $1.00 |
| 1110009100 | Vermont State Colleges | $3.00 |
| 1130030000 | Libraries | $26,000.38 |
| 1140010000 | Tax Operation Costs | $200,000.00 |

| | | |
|---|---|---|
| 1140040000 | Homeowner Rebates | $333,503.02 |
| 1140330000 | Renter Rebates | $1,712,964.82 |
| 1240001000 | Lieutenant Governor's Office | $20,672.89 |
| 2130200000 | Sheriffs | $542,914.55 |
| 2140010000 | DPS – State Police | $13,666,973.39 |
| 2170010000 | Criminal Justice Trng Council | $62,049.00 |
| 2280001000 | Human Rights Commission | $9,101.68 |
| 3150891901 | Copeland Center | $5,803.03 |
| 3330010000 | Green Mountain Care Board | $0.44 |
| 3400001000 | Secretary's Office Admin Costs | $50,000.00 |
| 3400002000 | RSVP Appropriation | $1,035.00 |
| 3400891902 | Elec Med/Health Records Syst | $3,894.00 |
| 3410017000 | DVHA-Programs-ST-Only Funded | $76,450.02 |
| 3420010000 | Administration | $650,000.00 |
| 3420021000 | Public Health | $1,784,782.61 |
| 3420892110 | VDH-Data Collection | $134,000.00 |
| 3440060000 | DCFS - General Assistance | $4,374,450.77 |
| 3440891903 | Parent Child Centers | $18,089.40 |
| 3440891906 | Incentivizing Child Care Profs | $96,628.40 |
| 3440891908 | Weatherization Assist Bridge | $290,035.94 |
| 3460020000 | Advocacy & Indep Living Grants | $241,585.88 |
| 3480004000 | Corrections-Correctional Services | $6,361,238.22 |

| | | |
|---|---|---|
| 5100010000 | Administration | $118,500.00 |
| 5100060000 | Adult Basic Education | $63,476.19 |
| 5100070000 | Education Services | $51,719.84 |
| 5100210000 | Ed-Flexible Pathways | $10,675.00 |
| 5100891807 | Restorative Justice Grants | $75,867.34 |
| 5100891901 | AOE New Positions | $214,729.59 |
| 6100040000 | Property Tax Assessment Approp | $0.93 |
| 6130010000 | Administration | $0.70 |
| 7100892107 | ACCD-Public Access TV | $30,450.10 |
| 7120892001 | ThinkVermont Initiative | $45,000.00 |

(e) Notwithstanding any provision of law to the contrary, in fiscal year 2022, the following amounts shall revert to the Education Fund from the accounts indicated:

| | | |
|---|---|---|
| 1140060000 | Reappraisal & Listing Payments | $0.13 |
| 5100010000 | Administration | $950,949.54 |
| 5100040000 | Special Education Formula | $5,824,528.53 |
| 5100050000 | State-Placed Students | $880,000.00 |
| 5100090000 | Education Grant | $0.69 |
| 5100110000 | Small School Grant | $614,965.00 |
| 5100190000 | Essential Early Educ Grant | $41,295.67 |
| 5100200000 | Education-Technical Education | $1,841,126.00 |
| 5100210000 | Ed-Flexible Pathways | $1,579,282.05 |

(f) Notwithstanding any provision of law to the contrary, in fiscal year 2022, the following amount shall revert to the Transportation Fund from the account indicated:

2140010000 DPS-State Police $3,933,026.61

(g) Notwithstanding any provision of law to the contrary, in fiscal year 2022, the following amount shall revert to the Clean Water Fund from the account indicated:

6140040000 Environmental Conservation – Office of Water Programs

Office of Water Programs $675,149.73

Sec. 49 2021 Acts and Resolves No. 74, Sec. D.102 is amended to read:

Sec. D.102 27/53 RESERVE; TRANSFER AND USE

(a) ~~$3,740,000~~ $4,770,000 from the General Fund shall be reserved in the 27/53 reserve in fiscal year 2022. This action is the fiscal year 2022 contribution to the reserve for the 53rd week of Medicaid as required by 32 V.S.A. § 308e and the 27th payroll reserve as required by 32 V.S.A. § 308e(b).

(b) ~~$24,030,000~~ $25,060,000 shall be unreserved from the 27/53 Reserve in in fiscal year 2022 to provide for the appropriations described in Secs. B.1106(a)(1)(A) and B.1106(a)(1)(B) of this act.

Sec. 50. 2021 Acts and Resolves No. 74, Sec. E.107 is amended to read:

Sec. E.107 CORONAVIRUS RELIEF FUND APPROPRIATIONS; REVERSION AND REALLOCATION; REPORTS

(a) The Commissioner of Finance and Management is authorized to revert all unobligated Coronavirus Relief Fund (CRF) appropriations prior to December 31, 2021. The total amount of CRF monies reverted in accordance with this subsection shall be allocated pursuant to 32 V.S.A. § 511 to any agency or department for CRF-eligible costs incurred from ~~July 1, 2021~~ March 1, 2020 through December 31, 2021.

(b) If previously obligated CRF monies become unobligated after December 31, 2021, the Commissioner of Finance and Management is authorized to revert the unobligated CRF appropriations and allocate the monies for expenditure pursuant to 32 V.S.A. § 511 to any agency or department for CRF-eligible costs incurred from ~~July 1, 2021~~ March 1, 2020 through December 31, 2021.

Sec. 51. CORONAVIRUS RELIEF FUND REALLOCATION

(a) Pursuant to 2021 Acts and Resolves No. 74, Sec. E.107 as amended by Sec. 50 of this act, the following amount is reallocated from the Coronavirus Relief Fund to the following eligible appropriation:

(1) To the Agency of Education for Local Educational Agency (LEA) grants: $436,217.22.

Sec. 52. [Deleted.]

Sec. 53. FISCAL YEAR 2022 UNALLOCATED RESERVE

(a) After satisfying the requirements of 32 V.S.A. § 308, and after other reserve requirements have been met, but prior to satisfying the requirements of 32 V.S.A. § 308c, the first $86,000,000 of remaining unreserved and undesignated funds at the close of fiscal year 2022 shall remain in the General Fund and be carried forward to fiscal year 2023. These funds may be used to provide state match to the federal Infrastructure Investment and Jobs Act.

(b) After meeting the requirements of subsection (a) of this section, but prior to satisfying the requirements of 32 V.S.A. § 308c, the remaining unreserved and undesignated funds at the close of fiscal year 2022 shall be allocated as follows:

(1) $850,000 shall be transferred to the to the Cannabis Regulation Fund (21998).

(2) $1,700,000 to the State Liability Self-Insurance Fund (56200).

(3) $1,877,092 to the Correctional Industries Internal Services Fund (59100).

(4) $9,961,531 to the Agency of Human Services-Central Office-Global Commitment to offset one-time pressure related to the suspension of Medicaid eligibility redeterminations for fiscal year 2023. This appropriation is made to the extent the Global Commitment fiscal need is identified after analysis of the impact of continued enhanced pandemic related Federal Medical Assistance Percentage (FMAP) in tandem with the updated analysis on the fiscal impact

related to caseload redetermination and cost per member per month. The Agency of Human Services, in consultation with the Joint Fiscal Office and the Department of Finance and Management shall provide this analysis as part of the Medicaid end-of-year report provided the Emergency Board in July 2022.

(5) $25,000,000 is reserved and carried forward into fiscal year 2023 to improve the debt position of the State. This may include the redemption of general obligation bonds, reducing the amount of new debt to be issued or to address negative internal fund balances.

(6) $25,114,179 is appropriated to the extent available and, in fiscal year 2022, the Commissioner of Finance and Management is authorized to replace American Rescue Plan Act – Coronavirus State Fiscal Recovery Funds appropriated in 2021 Acts and Resolves No. 74, Sec. G.300, as amended by Sec. 68 of this act, with General Fund dollars in the following amounts:

(A) $6,000,000 to replace the fund source in the appropriation in Sec. G.300(a)(23) (Vermont Foodbank);

(B) $1,001,913 to replace the fund source in the appropriation in Sec. G.300(a)(26) (adult day services);

(C) $4,934,590 to replace the fund source in the appropriation in Sec. G.300(a)(27) (Department of Corrections);

(D) $12,803,996 to replace the fund source in the appropriation in Sec. G.300(a)(28) (Department of Labor); and

(E) $373,680 to replace the fund source in the appropriation in Sec. G.300(a)(29) (Vermont Veterans' Home).

Sec. 54. GENERAL ASSISTANCE EMERGENCY HOUSING; TRANSITIONAL HOUSING; SOURCE OF FUNDS

(a) The Department for Children and Families shall continue to make emergency housing available through the General Assistance Emergency Housing program to individuals and families through June 30, 2022, using eligibility criteria in effect on January 1, 2022.

(b) The Adverse Weather Conditions policy in effect on November 22, 2021 shall continue in effect until March 31, 2022 using 100 percent FEMA funds and through the end of the fiscal year using either 100 percent FEMA funds or Emergency Rental Assistance Program (ERAP) funds.

(c)(1) The Commissioner for Children and Families shall reconvene the General Assistance working group described in 2021 Acts and Resolves No. 74, sections E.321 and E.321.2 for the purpose of assisting with the development of rules for a transitional housing program, which shall be funded by federal ERAP funds. The Department shall initiate emergency rulemaking as soon as practicable and shall be deemed to have met the emergency rulemaking criteria in 3 V.S.A. § 844. The Department shall file permanent rules pursuant to 3 V.S.A. chapter 25 concurrently with its emergency rule filing.

(2) Notwithstanding subsection (a) of this section, once emergency rules have been adopted for the ERAP-funded transitional housing program, and if the Department has located housing through facilitated occupancy agreements with motels and hotels or other housing providers on behalf of program participants, the Department shall begin transitioning participating individuals and families from the General Assistance emergency housing program funded by 100 percent FEMA funds to the transitional housing program funded by ERAP funds prior to June 30, 2022.

(3) The Department is authorized to provide supplemental services as needed for the safety of program participants and providers to the extent that ERAP or 100 percent FEMA funds are available for this purpose.

Sec. 54a. 9 V.S.A. § 4452 is amended to read:

§ 4452. EXCLUSIONS

Unless created to avoid the application of this chapter, this chapter does not apply to any of the following:

* * *

(8) transient occupancy in a hotel, motel, or lodgings during the time the occupant is a recipient of General Assistance or Emergency Assistance temporary housing assistance, or occupancy in a hotel or motel funded by federal Emergency Rental Assistance administered by the Department for Children and Families through September 30, 2025, regardless of whether the occupancy is subject to a tax levied under 32 V.S.A. chapter 225;

* * *

Sec. 55. 2021 Acts and Resolves No. 74, Sec. E.126 is amended to read:

Sec. E.126 TRANSFER OF FUNDS WITHIN LEGISLATIVE BRANCH

(a) Notwithstanding 32 V.S.A. § 706, in fiscal year 2022, appropriations within the Legislative Branch may be transferred between respective offices to ensure a balanced close-out in the fiscal year.

(b) The Joint Fiscal Office shall be reimbursed by a transfer from the Legislative budget for any costs incurred in contracting with an economist or independent consulting entity for the study created in 2021 Acts and Resolves No. 45, Sec. 14.

Sec. 56. FISCAL YEAR 2022; STATE HOUSE EXPANSION; REQUEST FOR PROPOSAL; SERGEANT AT ARMS; DEPARTMENT OF BUILDINGS AND GENERAL SERVICES; GENERAL FUND CARRYFORWARD

(a) On or before May 1, 2022, the Department of Buildings and General Services, in collaboration with the Sergeant at Arms, shall develop and issue a request for proposal (RFP) for programming, schematic design, and the initial phase of design development documents for an expansion of the State House, including the infrastructure needs for any future phases of expansion.

(b) Upon approval and funding from the General Assembly, it is the intent of the General Assembly that the Sergeant at Arms and the Department of Buildings and General Services will extend the RFP for architectural and

engineering services to finalize design development and construction and bid documents.

Sec. 57. 2021 Acts and Resolves No. 74, Sec. E.215 is amended to read:

Sec. E.215 Military – Administration

(a) The amount of ~~$1,119,834~~ $934,290 shall be disbursed to the Vermont Student Assistance Corporation for the National Guard educational assistance program established in 16 V.S.A. § 2856 and the National Guard Tuition Benefit Program established in 16 V.S.A. § 2857.

Sec. 58. [Deleted.]

Sec. 59. CANNABIS CONTROL BOARD

(a) The establishment of the following eight (8) new permanent classified positions are authorized in fiscal year 2022:

(1) One (1) Licensing Director;

(2) Two (2) Licensing Administrators;

(3) One (1) Policy Enforcement Director;

(4) Three (3) Compliance Officers; and

(5) One (1) Financial Manager.

Sec. 59a. 2021 Acts and Resolves No. 62, Sec. 15 is amended to read:

Sec. 15. IMPLEMENTATION OF MEDICAL CANNABIS REGISTRY

(a) On January 1, 2022, the following shall transfer from the Department of Public Safety to the Cannabis Control Board:

(1) the authority to administer the Medical Cannabis Registry and the regulation of cannabis dispensaries pursuant to 18 V.S.A. chapter 86;

(2) the cannabis registration fee fund established pursuant to 18 V.S.A. chapter 86; and

(3) the positions dedicated to administering 18 V.S.A. chapter 86.

(b) The Registry shall continue to be governed by 18 V.S.A. chapter 86 and the rules adopted pursuant to that chapter until 7 V.S.A. chapters 35 and 37 and the rules adopted by the Board pursuant to those chapters take effect on ~~March 1, 2022~~ July 1, 2022 as provided in 2019 Acts and Resolves No. 164.

Sec. 59b. 2019 Acts and Resolves No. 164, Sec. 33 is amended to read:

Sec. 33. EFFECTIVE DATES

* * *

(d) Secs. ~~9 (Medical Cannabis Registry chapter), except for 7 V.S.A. § 956 (rulemaking); 11 (Repeal); 12 (Medical Cannabis Dispensaries), except for 7 V.S.A. § 974 (rulemaking);~~ 14 (creation of excise tax); 14a (tax license disclosure); 15 (sales tax exemption); 16 (tax exemption); 17 (tax expenditure); 17a (meals and rooms tax); 17b (meals and rooms tax expenditure); and 17c (dedicated use of sales and use tax revenue) shall take effect March 1, 2022.

(e) ~~Sec.~~ Secs. 6d (Auditor of Accounts report); 9 (Medical Cannabis Registry chapter), except for 7 V.S.A. § 956 (rulemaking); 11 (Repeal); and 12 (Medical Cannabis Dispensaries), except for 7 V.S.A. § 974 (rulemaking), shall take effect on July 1, 2022.

* * *

Sec. 60. 2021 Acts and Resolves No. 74, Sec. E.301 is amended to read:

Sec. E.301 SECRETARY'S OFFICE – GLOBAL COMMITMENT:

* * *

(b) In addition to the State funds appropriated in this section, a total estimated sum of ~~$24,993,731~~ $25,220,180 is anticipated to be certified as State matching funds under the Global Commitment as follows:

* * *

(2) ~~$2,773,731~~ $3,000,180 certified State match available from local designated mental health and developmental services agencies for eligible mental health services provided under Global Commitment.

(c) Up to ~~$4,618,437~~ $4,034,170 is transferred from the AHS Federal Receipts Holding Account to the Interdepartmental Transfer Fund consistent with the amount appropriated in Sec. B.301 of this act – Secretary's Office – Global Commitment.

Sec. 60a. MEDICAID; POSTPARTUM COVERAGE; STATE PLAN AMENDMENT

(a) The Agency of Human Services shall seek to amend Vermont's Medicaid state plan to extend Medicaid coverage to 12 months postpartum for eligible individuals as permitted under Sec. 9812 of the American Rescue Plan Act of 2021, Pub. L. No. 117-2.

Sec. 61. DEPARTMENT FOR CHILDREN AND FAMILIES

(a) $2,000,000 of federal spending authority for the Department for Children and Families' administrative division, to be established pursuant to 32 V.S.A. § 511, shall be used for federal matching funds to implement the first phase of the Comprehensive Child Welfare Information System in Vermont in accordance with 45 C.F.R. § 1355.55.

Sec. 62. 2021 Acts and Resolves No. 74, Sec. E.335 is amended to read:

Sec. E.335 CORRECTIONS APPROPRIATIONS; UNEXPENDED FUNDS TRANSFER; JUSTICE REINVESTMENT; REPORT

* * *

(b) In fiscal year 2022, any unexpended funds for correctional services out-of-state beds shall be carried forward to fiscal year 2023, and the amount reported to the Joint Legislative Justice Oversight Committee in September 2022, to ~~support~~ provide additional funding to community-based service programs in support of Justice Reinvestment II initiatives. Funds may only be expended on community-based service programs upon approval of the Joint Legislative Justice Oversight Committee. Prior to approval, the House Committees on Appropriations and on Corrections and Institutions and the Senate Committees on Appropriations and on Judiciary shall be notified of any proposed expenditures on community-based service programs.

Sec. 63. 2021 Acts and Resolves No. 74, Sec. E.501.1(a) is amended to read:

(a) ESSER I funds. The following sums are appropriated to the Agency of Education in fiscal year 2021 from the ESSER funds provided to the State pursuant to Section 18003 of Division B of the Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116–136 (CARES Act); a portion of the funds may be expended in fiscal year 2020 consistent with the terms of the grant acceptance, and any unexpended amounts may be carried forward to fiscal years 2022 and after:

(1) $953,021 for software tools to assist with the response to the COVID-19 pandemic;

(2) ~~$2,006,074~~ $1,006,074 for learning management assistance, including remote learning supports and materials; and

(3) $1,000,000 for emerging State-level needs; and

(4) $155,741 for administrative and personnel costs.

Sec. 64. 2021 Acts and Resolves No. 74, Sec. E.501.2(b) is amended to read:

(b) ESSER III funds. The federal funds appropriated in Sec. B.501 of this act shall be allocated as follows:

(1) $1,000,000 from the ESSER funds provided to the State pursuant to Sec. 2001(f) of the American Rescue Plan Act of 2021, Pub. L. No. 117-2 ~~to address emerging State-level needs~~ for learning management assistance, including remote learning supports and materials; and

* * *

Sec. 65. 2020 Acts and Resolves No. 120, Sec. A.51, as amended by 2020 Acts and Resolves No. 154, Sec. B. 1113 is further amended to read:

Sec. A.51. SCHOOL INDOOR AIR QUALITY GRANT PROGRAM; CORONAVIRUS RELIEF FUND; APPROPRIATION

* * *

(c) Definition. As used in this section, "covered school" means public schools, regional career technical center school districts as defined in 16 V.S.A. 1571, regional CTE centers as defined in 16 V.S.A 1522, and approved independent schools as defined under 16 V.S.A. § 11.

* * *

Sec. 65a. ONE-TIME FISCAL YEAR 2022 TECHNICAL EDUCATION SUPPLEMENTAL GRANT FUNDING

(a) In fiscal year 2022, $1,725,000 is appropriated from the Education Fund to the Agency of Education to make supplemental grants to career technical education centers. The grants shall be made proportionally based on fiscal year 2019 through 2021 average headcount of attendees at each center.

Sec. 66. 2021 Acts and Resolves No. 74, Sec. E.311.3 to read:

Sec. E.311.3 EDUCATIONAL ASSISTANCE; MEDICAL STUDENT INCENTIVE SCHOLARSHIP PROGRAM; APPROPRIATION

* * *

(b) This funding shall remain available to VSAC until expended, and if needed, fiscally neutral adjustments to spending authority shall be included in future budget legislation.

Sec. 67. 2021 Acts and Resolves No. 74, Sec. E.602.2(c) is added to read:

(c) Vermont State College System (VSCS) shall use funds remaining with Vermont Technical College provided in 2019 Acts and Resolves No. 80 to continue to study a model for course delivery at Career and Technical Education (CTE) centers in Vermont and pilot up to two programs that offer these degree programs in up to two CTE centers. On or before January 15, 2023, the VSCS shall submit a written supplemental report to the House and Senate Committees on Education and the State Board of Education with its findings and recommendations from the pilot programs.

Sec. 67a. REAFFIRMATION OF MULTIYEAR FUNDING PRIORITIES FOR AMERICAN RESCUE PLAN ACT (ARPA) AND OTHER FEDERAL AND STATE FUNDS

(a) In 2021 Acts and Resolves No. 74, Sec. G.100, the General Assembly recognized that ARPA State Fiscal Relief funds, along with other federal or State funds, offer the unprecedented opportunity to invest in Vermont's recovery and long-term future by supporting Vermonters' health and well-being and by strengthening Vermont's communities, businesses, environment, and climate.

(b) In November 2021, the federal Infrastructure Investment and Jobs Act (IIJA) was enacted. This federal law includes unprecedented levels of federal investments for broadband; water, transportation, and electricity infrastructure; environmental remediation; information technology including cybersecurity; and carbon reduction and climate resilience strategies. The law authorizes approximately $1.2 trillion of funding over five years, of which approximately $550 billion is newly authorized spending, for transformative investments in these critical infrastructure systems. The law provides for formula funding to states, as well as competitive grants that states may apply for to seek additional funding, with nearly 50 percent of the additional funding allocated for nontransportation investments. While match requirements vary by project and funding stream, the additional state match requirements necessary to draw down the nontransportation formula and competitive grant funding will be substantial.

(c) The General Assembly reaffirms the intention of 2021 Acts and Resolves No. 74, Sec. G.100 and will seek to make the budget and appropriations processes of the 2022 legislative session consistent with the need to create State fiscal capacity to maximize the federal funding opportunities in the IIJA for broadband; information technology including cybersecurity; water; energy; and climate initiatives.

Sec. 68. 2021 Acts and Resolves No. 74, Sec. G.300 is amended to read:

Sec. G.300 INVESTMENTS IN VERMONT'S ECONOMY, WORKFORCE, AND COMMUNITIES

(a) ~~$109,200,000~~ $187,114,176 in fiscal year 2022 is appropriated from the American Rescue Plan Act (ARPA) - Coronavirus State Fiscal Recovery Funds as follows:

* * *

(7) ~~$1,000,000~~ $2,000,000 in fiscal year 2022 to the University of Vermont.

(A) $1,000,000 for matching funds for research grant opportunities related to COVID-19.

(B) $1,000,000 to provide up to two free classes in calendar year 2022 for any Vermont resident who is seeking to transition to a new career or to enhance the resident's job skills.

(8) ~~$10,000,000~~ $19,700,000 in fiscal year 2022 to the Vermont State Colleges for the following programs; funds shall be carried forward until expended:

(A) $2,000,000 to provide funding for up to six credits or two courses in the 2022–2023 academic year, including wraparound services for Vermonters whose employment was impacted by the COVID-19 public health emergency since March 13, 2020. The wraparound services may also be provided to students who enroll in six credit hours or two courses in the

summer or fall of 2021 and spring of 2022 pursuant to 2021 Acts and Resolves No. 9, Sec. 18.

(B) $3,000,000 to provide degree completion scholarships for up to 30 credits towards a credential of value for adult learners who have earned at least 40 credits towards an undergraduate degree and have a gap in attendance of at least two years.

(C) ~~$5,000,000~~ $14,700,000 to provide free last dollar tuition for one year of undergraduate studies for critical occupation careers, including bookkeeping certificate, IT service desk specialist certificate, certified production technician, graphic design certificate, software and web development program, electrical and plumbing apprenticeships, dental hygiene, certificate in accounting, small business management, radiologic science, and respiratory therapy. $540,000 of these funds shall be allocated for paramedic/EMS programs and any unexpended amount of this allocation shall be available for the broader purpose in this subdivision (C). Funds may be used for practical nursing, childcare, nursing, and mental health counseling programs only after available federal and State financial aid is applied to ensure no cost to the student. Of this amount, $7,350,000 shall be carried forward for the 2022–2023 school year. If demand from undergraduates is met, then funds may be used to pay for tuition for the following graduate programs:

(i) Master in Education (all programs);

(ii) Master in Educational Leadership;

(iii) Master of Arts and Certificate of Advanced Graduate Studies in School Psychology;

(iv) Masters in Counseling; and

(v) Masters in Clinical Mental Health Counseling.

* * *

(22) $2,320,000 to the Agency of Commerce and Community Development for Working Community Challenge grants.

(23) $6,000,000 to the Department for Children and Families to be granted to the Vermont Foodbank.

(24) [Deleted.]

(25) $2,000,000 to the Agency of Agriculture, Food and Markets for grants to be made to eligible projects in the Working Lands Enterprise Initiative.

(26) $1,001,913 to the Department of Disabilities, Aging, and Independent Living to be granted to Adult Day service providers to maintain operations through June 30, 2022.

(27) $4,934,590 to the Department of Corrections for costs associated with the collective bargaining unit related to retention and shift differential.

(28) $12,803,996 to the Department of Labor to cover pandemic related operating costs in the Unemployment system and other programs.

(29) $373,680 to the Vermont Veteran's Home for retention and personal protective equipment related expenses.

(30) $6,000,000 to the Department for Children and Families to be granted to childcare providers to address emergent and exigent circumstances following the COVID-19 pandemic for workforce retention bonuses to retain early childhood staff and home-based providers. It is the intent of the General Assembly that the eligible employers awarded funds pursuant to this section shall use the funds to make retention payments to their employees. The employers shall be afforded flexibility in determining how best to provide the financial retention assistance to their employees and how best to encourage employment beyond the terms of this program.

(A) The Department is authorized to establish parameters related to minimum hours worked for an employee or home-based provider to be eligible for a bonus under this subdivision (30), and to design a program that does not allow for duplication of bonuses to staff who work for more than one provider. Staff under a teacher contract shall not be eligible for this program.

(B) Notwithstanding any provision of Vermont law to the contrary and to the extent permitted under federal law, the amount of a recruitment or retention payment received by an employee under this section shall be disregarded for purposes of determining the employee's or employee's household's income eligibility for any benefit program.

(31) $30,000,000 to the Agency of Human Services for a program to provide workforce recruitment and retention funding as specified in Sec. 72 of this act. These funds are combined with other funding provided in Sec. 72 for total $60,000,000 retention payment program.

(32) $1,500,000 to the Department of Buildings and General Services to develop and issue the request for proposal for the State House expansion planning design, provided that any funds remaining unobligated by October 1, 2023 shall be reverted and made available for reallocation.

(33) $2,600,000.00 to the Agency of Agriculture, Food and Markets for purposes of implementing the Dairy Risk Management Assistance Program established under Sec. 77 of this act. Funds appropriated under this section that are unexpended in fiscal year 2022 shall carry forward for use by the Agency of Agriculture, Food and Markets in providing risk management assistance for dairy farmers in fiscal year 2023.

* * *

Sec. 69. 2021 Acts and Resolves No. 74, Sec. G.400 is amended to read:

Sec. G.400 HOUSING AND HOMELESSNESS INVESTMENTS

(a) ~~$99,000,000~~ $124,000,000 in fiscal year 2022 is appropriated from the American Rescue Plan Act (ARPA) - Coronavirus State Fiscal Recovery Funds as follows:

(1) ~~$94,000,000~~ $119,000,000 to the Vermont Housing and Conservation Board (VHCB) to provide housing and increase shelter capacity,

with priority given to populations who may be displaced from the hotel/motel voucher problem or are currently without housing, including by providing permanent homes in mixed-income settings. VHCB shall distribute the funds in consultation with the Secretary of Human Services and may subgrant a portion to other entities, including the Department of Housing and Community Development, the Vermont Housing Finance Agency, and regional nonprofit housing organizations, for one or more of the following purposes:

(A) if necessary, to help ensure that households and areas impacted by the pandemic are served;

(B) to undertake additional housing initiatives, such as home ownership, to the extent permitted by ARPA and related regulations and guidance; or

(C) to provide for the efficient use of the funds.

* * *

(b) ~~$91,000,000~~ $121,000,000 is appropriated from other funds as follows:

(1) $40,000,000 in fiscal year 2021 is appropriated from the General Fund to the Vermont Housing and Conservation Board (VHCB) for affordable housing initiatives. These funds shall carryforward into fiscal year 2022 and are in addition to funding provided to VHCB in 2021 Acts and Resolves No. 9 and $30,000,000 in fiscal year 2022 is appropriated from the General Fund to the Vermont Housing and Conservation Board (VHCB) for affordable housing initiatives.

* * *

Sec. 69a. 2021 Acts and Resolves No. 74, Sec. G.600 is amended to read:

Sec. G.600 CLIMATE ACTION INVESTMENTS

(a) ~~$50,000,000~~ $41,000,000 in fiscal year 2022 is appropriated from the American Rescue Plan Act - Coronavirus State Fiscal Recovery Funds as follows:

(1) $4,000,000 to the Department for Children and Families, Office of Economic Opportunity, Home Weatherization Assistance Program to be used in fiscal years 2022 and 2023. Up to $150,000 of these funds may be used for vermiculite remediation and home repair as part of home weatherization. These funds are in addition to the funds that are provided in Sec. B.324 of this act and the federal ARPA LIHEAP funding provided, as set forth in Sec. E.324.1 of this act.

(2) ~~$9,000,000 to the Agency of Administration to grant to the Vermont Housing Finance Agency for financial support of housing weatherization statewide. On or before January 31, 2022 and thereafter upon request from a legislative committee, the Vermont Housing Finance Agency shall issue a report to the General Assembly detailing the programs to which funds appropriated under this subdivision were provided. The report shall include the results of its investigations into on-bill to-the-meter billing and other methods to provide weatherization financing.~~

~~(3)~~ $5,000,000 to the Department of Public Service to grant to the Efficiency Vermont for the purpose of weatherization incentives. These funds shall be deposited in Electric Efficiency Fund established under 30 V.S.A. § 209(d)(3) and shall be available for use by Efficiency Vermont through December 31, 2023.

~~(4)~~(3) $2,000,000 to the Department of Public Service to grant to Efficiency Vermont for the purpose of workforce development initiatives and to support the expansion of NeighborWorks of Western Vermont's Heat Squad program. These funds shall be deposited in the Electric Efficiency Fund established under 30 V.S.A. § 209(d)(3) and shall be available for use by Efficiency Vermont through December 31, 2023.

~~(5)~~(4) $20,000,000 to the Department of Public Service of which $10,000,000 is to be used on the Affordable Community-Scale Renewable Energy Program, consistent with parameters of the Clean Energy Development Fund, to support the creation of renewable energy projects for Vermonters with low-income. In fiscal year 2022, $5,000,000 may be allocated by the Clean Energy Development Board. The Department shall submit a plan for use of the remaining $5,000,000 funds for approval by the General Assembly during the 2022 legislative session.

~~(6)~~(5) $10,000,000 to the Vermont Housing Conservation Board, which may be used for conservation projects and Farm and Forest Viability Program

activities that support the rural economy. Up to $100,000 shall be used to expand the Rural Economic Development Initiative (REDI).

(b) ~~$4,500,000~~ $13,500,000 in fiscal year 2022 is appropriated from the General Fund as follows:

* * *

(4) $9,000,000 to the Agency of Administration to grant to the Vermont Housing Finance Agency for financial support of housing weatherization statewide. On or before January 31, 2022 and thereafter upon request from a legislative committee, the Vermont Housing Finance Agency shall issue a report to the General Assembly detailing the programs to which funds appropriated under this subdivision were provided. The report shall include the results of its investigations into on-bill to-the-meter billing and other methods to provide weatherization financing.

Sec. 70. 2021 Acts and Resolves No. 74, Sec. G.700(a)(4)(B)(i) is amended to read:

(i) $1,000,000 to increase the funds available for grants and loan forgiveness to replace failed or inadequate residential on-site wastewater and water supply systems.

Sec. 71. 2021 Acts and Resolves No. 74, Sec. G.700(a)(5) is amended to read:

(5) $10,000,000 ~~to the Department of Environmental Conservation for allocation by the Clean Water Board established under 10 V.S.A § 1389, as~~

~~part of their budget process in fiscal year 2022~~ for water quality initiatives to be allocated as follows:

(A) $6,500,000 to the Department of Environmental Conservation for municipal water control grants and storm water project delivery, planning, and implementation.

(B) $3,500,000 to the Agency of Agriculture, Food and Markets for water quality grants to partners and farmers.

Sec. 71a. AMERICAN RESCUE PLAN ACT; PREVAILING WAGE REQUIREMENT

(a)(1) Except as provided in subsection (b) of this section, any contract awarded for a maintenance, construction, or improvement project that receives $200,000.00 or more in American Rescue Plan Act (ARPA) funds shall provide that all construction employees working on the project shall be paid not less than the mean prevailing wage published periodically by the Vermont Department of Labor in its occupational employment and wage survey plus an additional fringe benefit of 42 and one-half percent of wage, as calculated by the current Vermont prevailing wage survey.

(2) As used in this subsection, "fringe benefits" has the same meaning as used in 29 V.S.A. § 161.

(b) The requirements of subsection (a) of this section shall not apply to any maintenance, construction, or improvement project that received $200,000.00 or more in American Rescue Plan Act (ARPA) funds appropriated prior to the

effective date of this act if any of the following apply as of the effective date of this act:

(1) the project has been invited or advertised for bid;

(2) the project is under contract; or

(3) the funds are obligated.

(c) Subsection (a) of this section shall not apply to contracts awarded for maintenance, construction, or improvements projects that are required by law to comply with the requirements of the federal Davis-Bacon Act.

Sec. 72. WORKFORCE RECRUITMENT AND RETENTION INCENTIVE GRANT FUNDING FOR EMPLOYEES OF ELIGIBLE HEALTH CARE AND SOCIAL SERVICE EMPLOYERS

(a)(1) Program established. The Secretary of Human Services shall establish a workforce recruitment and retention incentive grant program for employees of eligible employers, as defined in this section. Eligible employers may apply for a grant within the grant application period determined by the Secretary.

(2) The total grant award amount for each eligible employer shall be calculated at a rate of $2,000 per full-time equivalent employee (FTE) based on the number of FTEs identified by the eligible employer in its grant application.

(3) In order to be eligible to receive a recruitment or retention incentive payment funded by a grant awarded pursuant to this section, an employee shall

commit to continuing employment with the eligible employer for at least one calendar quarter following receipt of the payment.

(4) Eligible employers shall distribute the full amount of their awards within 12 months following receipt of the grant funds.

(b) Definition. As used in this section, "eligible employers" means:

(1) assisted living residences, as defined in 33 V.S.A. § 7102;

(2) nursing homes, as defined in 33 V.S.A. § 7102;

(3) residential care homes, as defined in 33 V.S.A. § 7102;

(4) home health agencies, as defined in 33 V.S.A. § 6302;

(5) designated and specialized service agencies, including shared living providers;

(6) substance use treatment providers in the Department of Health's preferred provider network;

(7) recovery centers;

(8) adult day service providers;

(9) area agencies on aging; and

(10) programs licensed by the Department for Children and Families as residential treatment programs.

(c) Independent direct support providers. For the purpose of administering recruitment and retention incentive payments to independent direct support providers, ARIS Solutions, as the fiscal agent for the employers of independent direct support providers, is authorized to apply for a grant in the same manner

as an eligible employer and to disburse incentive payments funded by the grant to eligible independent direct support providers in a manner consistent with ARIS Solutions' payroll practices, to the extent that making those awards is not inconsistent with the terms of the collective bargaining agreement between the Agency of Human Services and the independent direct support providers.

(d) Intent; flexibility; payment disregard.

(1) It is the intent of the General Assembly that the eligible employers awarded funds pursuant to this section shall use the funds to make recruitment and retention incentive payments to their employees and prospective employees. The employers shall be afforded flexibility in determining how best to provide these incentive payments and how best to encourage continued employment beyond the service commitment set forth in subdivision (a)(3) of this section.

(2) Notwithstanding any provision of Vermont law to the contrary and to the extent permitted under federal law, the amount of a recruitment or retention incentive payment received by an existing or prospective employee of an eligible employer under the program established in this section shall be disregarded for purposes of determining the employee's or employee's household's income eligibility for any benefit program.

(e) Available funds.

(1) The sum of $60,000,000 shall be made available to the Agency of Human Services in fiscal year 2022 to fund the workforce recruitment and

retention incentive grant program established in this act, from the following sources:

(A) $25,000,000 as appropriated in Sec. 72a(a)(2) to the Agency of Human Services in fiscal year 2022 from the Global Commitment Fund. The Agency shall amend the American Rescue Plan Act Home and Community-Based Services plan it submitted to the Centers for Medicare and Medicaid Services if needed to reflect this allocation.

(B) $5,000,000 is appropriated to the Agency of Human Services in fiscal year 2022 from the General Fund. These funds may be included among the Global Commitment appropriations referenced in 2021 Acts and Resolves No. 74, Sec. E.301.2 as available for transfers if it is determined that grants made under this provision can be included and matched in the Global Commitment waiver. These funds shall carry forward if not fully expended in fiscal year 2022.

(C) $30,000,000 shall be made available to support the program from the funds allocated to the Agency of Human Services from the American Rescue Plan Act of 2021 – Coronavirus State Fiscal Recovery Fund in 2021 Acts and Resolves No. 74, as amended by Sec. 68 of this act.

(2) The Agency of Human Services may use up to 1.5 percent of funds allocated in subdivision (1) of this subsection to administer the program.

(f) Allocations. Of the funds made available in subsection (e) of this section, $45,000,000 shall be allocated for a first round of funding, to be made

available to the eligible employers identified in subsection (b) of this section. The remaining $15,000,000 shall be reserved for a second round of funding pending identification of a set of additional health care and social service provider employers with a demonstrated need for the recruitment and retention incentive grant funding, as recommended by the Agency of Human Services and accepted by the General Assembly, or by the Joint Fiscal Committee if the General Assembly is not in session, except that the Agency is authorized to access all or a portion of the reserved funding to the extent that a funding deficiency is identified when meeting the needs of the first round of eligible employers.

(g) Reporting requirements.

(1) On or before April 15, 2022, the Secretary of Human Services shall report to the House Committees on Appropriations, on Health Care, and on Human Services and the Senate Committees on Appropriations and on Health and Welfare regarding the status of implementation of the workforce recruitment and retention incentive grant program.

(2) On or before July 1, 2022, the Secretary shall provide an update on the program to the Joint Fiscal Committee, including the amount of funding distributed to date, the amount of funding remaining for distribution, and any anticipated funding deficiency for the first round of grants based on the remaining need.

Sec. 72a. MEDICAID HOME- AND COMMUNITY-BASED SERVICES (HCBS) PLAN

(a) Pursuant to Sec. 9817 of the American Rescue Plan Act (ARPA), in October 2021, the State submitted a home- and community-based services (HCBS) spending plan to the Centers for Medicare and Medicaid Services. This plan currently totals $146,600,000, consisting of the following major components:

(1) $77,800,000 allocated to improve services;

(2) $25,000,000 allocated to promote a high-performing and stable HCBS workforce; and

(3) $43,800,000 allocated to improve HCBS care through data systems, value-based payment models, and oversight.

(b) The Agency of Human Services (AHS) is authorized to transfer General Fund appropriations made in fiscal year 2022 in the Global Commitment line to a new, one-time General Fund HCBS appropriation departmental ID. The amount transferred shall be not greater than the amount accounted for in fiscal year 2022 as a result of the 10 percent match rate allowed under ARPA Sec. 9817. The estimate of this transfer is between $65,000,000 and $69,000,000. Up to $7,540,128 of the funds transferred and appropriated in this subsection may be used in fiscal year 2022 as State matching funds in 2021 Acts and Resolves No. 74, Sec. B.301 for the $17,136,654 HCBS Global Commitment rate increases provided in 2021 Acts and Resolves No. 74. AHS

shall report to the Joint Fiscal Committee in July 2022 on the actual amount transferred pursuant to this authority and the amount expended as the state match for all the HCBS plan expenditures in fiscal year 2022. Funds transferred and appropriated under this subsection shall carry forward until expended and may only be used as state matching funds for the HCBS plan.

(c) In fiscal year 2022, a total of $59,457,740 is appropriated from the Global Commitment Fund to AHS to meet the objectives of the HCBS plan. This appropriation consists of $17,136,654 as appropriated in 2021 Acts and Resolves No. 74 for a three percent rate increase to HCBS providers, including the assistive community care rates and children integrated services rates, and the following appropriations in distinct one-time departmental IDs:

(1) $25,000,000 is appropriated for the retention and recruitment grant program for HCBS providers as specified in Sec. 72 of this act.

(2) $3,447,500 is appropriated to the Agency of Human Services – Secretary's Office.

(3) $2,370,000 is appropriated to the Department of Disabilities, Aging, and Independent Living.

(4) $6,171,000 is appropriated to the Department of Mental Health.

(5) $390,000 is appropriated to the Department of Vermont Health Access.

(6) $4,942,586 is appropriated to the Department of Health.

(d) The Global Commitment Fund appropriated in subsection (c) of this section may be obligated in fiscal year 2022 for the purposes of bringing HCBS plan spending authority forward into fiscal year 2023. The funds appropriated in subsections (b) and (c) of this section may be transferred on a net-neutral basis in fiscal year 2022 in the same manner as the Global Commitment appropriations referenced in 2021 Acts and Resolves No. 74, Sec. E.301.2. The Agency shall report to the Joint Fiscal Committee in September 2022 on transfers of appropriations made and final amounts expended by each department in fiscal year 2022 and any obligated funds carried forward to be expended in fiscal year 2023.

Sec. 73. 2020 Acts and Resolves No. 136, Sec. 7, as amended by 2020 Acts and Resolves No. 154, Sec. B.1121, and 2021 Acts and Resolves No. 3, Sec. 50, is further amended to read:

Sec. 7. AGENCY OF HUMAN SERVICES; HEALTH CARE PROVIDER STABILIZATION GRANT PROGRAM

* * *

(d) Specific allocations. Notwithstanding any provisions of this section to the contrary, of the funds appropriated in subsection (a) of this section, the Agency of Human Services shall make the following allocations for the following purposes:

* * *

(3) Up to $3,000,000.00 for COVID-19-related expenses incurred by designated and specialized service agencies through ~~December 30, 2020~~ December 31, 2021.

* * *

Sec. 74. HEALTH CARE PROVIDER STABILIZATION GRANT PROGRAM; ALTERNATIVE FUND DISTRIBUTION PROCESS

Notwithstanding any provision of 2020 Acts and Resolves No. 136, Sec. 7, as amended by 2020 Acts and Resolves No. 154, Sec. B.1121, 2021 Acts and Resolves No. 3, Sec. 50, and this act to the contrary, the Agency of Human Services may distribute funds from the Health Care Provider Stabilization Grant Program to eligible health care providers using an alternative process to that set forth in 2020 Acts and Resolves No. 136, Sec. 7, as amended, as deemed necessary by the Agency due to emergent and exigent circumstances attributable to the COVID-19 pandemic.

Sec. 75. 2019 Acts and Resolves No. 6, Sec. 105, as amended by 2019 Acts and Resolves No. 71, Sec. 19, is further amended to read:

Sec. 105. EFFECTIVE DATES

* * *

(b) Sec. 73 (further amending 32 V.S.A. § 10402) shall take effect on July 1, ~~2021~~ 2023.

* * *

Sec. 76. CARRYFORWARD AUTHORITY

(a) Notwithstanding any other provisions of law and subject to the approval of the Secretary of Administration, General, Transportation, Transportation Infrastructure Bond, Education Fund, Clean Water Fund (21932), and Agricultural Water Quality Fund (21933) appropriations remaining unexpended on June 30, 2022 in the Executive Branch of State government shall be carried forward and shall be designated for expenditure.

(b) Notwithstanding any other provisions of law, General Fund appropriations remaining unexpended on June 30, 2022 in the Legislative and Judicial Branches of State government shall be carried forward and shall be designated for expenditure.

Sec. 77. DAIRY MARGIN COVERAGE PROGRAM; PREMIUM ASSISTANCE

(a) As used in this section:

(1) "Dairy Margin Coverage Program" or "DMC" means a voluntary program authorized under the Farm Act that provides dairy operations with risk management coverage that will pay producers when the difference between the national price of milk and the average cost of feed falls below a certain level selected by the Program participants.

(2) "Farm Act" means the federal Agriculture Improvement Act of 2018, Pub. L. No. 115-334.

(3) "Good standing" means an applicant under this section that:

(A) does not have an active enforcement violation under any Agency of Agriculture, Food and Markets program that has reached a final order with the Secretary and is not subject to an ongoing enforcement action initiated by the Agency of Natural Resources; and

(B) is in compliance with all terms of a current grant agreement or contract with the Secretary.

(4) "Milk producer" or "producer" means a person, partnership, unincorporated association, or corporation who owns or controls one or more dairy cows, dairy goats, or dairy sheep and sells or offers for sale a part or all of the milk produced by the animals.

(5) "Secretary" means the Secretary of Agriculture, Food and Markets.

(b) The Secretary shall establish the Dairy Risk Management Assistance Program (Assistance Program) for the purpose of assisting milk producers that participate in the federal DMC management programs. A milk producer in Vermont that participates in the DMC at the first-tier coverage level may apply for reimbursement of premium payments from the Assistance Program. A milk producer shall be eligible for assistance if the producer:

(1) is in good standing with the Agency of Agriculture, Food and Markets and the Agency of Natural Resources; and

(2) provides proof of payment of an annual premium payment for participation in Tier 1 of DMC.

(c)(1) A milk producer shall apply to the Secretary on or before July 1, 2022 to participate.

(2) The Secretary shall reimburse eligible applicants in the order in which the Secretary receives administratively complete applications. The Secretary shall have the discretion to determine when an application is administratively complete.

(3) After funds are exhausted, applicants shall no longer be eligible for reimbursement from the Secretary unless or until additional funds are appropriated to the Assistance Program.

Sec. 78. EDUCATION FUND REFUND; CITY OF BARRE TIF DISTRICT; TAX INCREMENT; FISCAL YEAR 2016 – 2019

Notwithstanding 16 V.S.A. chapter 133 and any other provision of law to the contrary, the sum of $20,962 shall be transferred from the Education Fund to the City of Barre not later than fiscal year 2023 to compensate the City for overpayments of education property taxes in fiscal years 2016 to 2019 due to insufficient retention of tax increment from the City's Tax Increment Financing District Fund.

Sec. 79. 2021 Acts and Resolves No. 55, Sec. 20 is amended to read:

Sec. 20. MILEAGESMART

(a) The Agency is authorized to spend up to $750,000.00 in one-time Transportation Fund monies in fiscal years 2021 and 2022 combined and up to $500,000.00 in one-time General Fund monies in fiscal year 2022 on

MileageSmart, which was established in 2019 Acts and Resolves No. 59, Sec. 34, as amended, with up to ~~10~~ 15 percent of the total amount that is distributed in incentives in fiscal year 2022, including incentive funding authorized by this section and incentive funding carried over from prior fiscal years pursuant to 2019 Acts and Resolves No. 59, Sec. 34, as amended, available for costs associated with administering MileageSmart.

Sec. 80. [Deleted.]

Sec. 81. EFECTIVE DATES

This act shall take effect on passage except, notwithstanding 1 V.S.A. § 214:

(1) Secs. 73 (designated and specialized service agencies; COVID-19-related expenses) shall take effect retroactively on January 1, 2021;

(2) Secs. 74 (Health Care Provider Stabilization Grant Program; alternative fund distribution process) shall take effect retroactively on July 1, 2020; and

(3) Sec. 75 (health care claims tax) shall take effect retroactively on July 1, 2021.

Date Governor signed bill: March 16, 2022

VERMONT

# Proposed Rules Postings
# A Service of the Office of the Secretary of State



## Search Rules

### Deadline For Public Comment

Deadline: Unavailable.

The deadline for public comment is unavailable for this rule. Contact the agency or primary contact person listed below for assistance.

### Rule Details

| | |
|---|---|
| Rule Number: | 22-E10 |
| Title: | Nursing Home Rate Setting Staffing Adjustment. |
| Type: | Emergency |
| Status: | Adopted |
| Agency: | Division of Rate Setting, Agency of Human Services. |
| Legal Authority: | 33 V.S.A. § 908(c), 33 V.S.A. § 1901(a)(1), Act 85 of 2022 (H.654), and in response to Act 83 of 2022 (H.679), § 46. |
| Summary: | This emergency rule addresses costs at nursing homes associated with increased nursing staffing costs by increasing the existing inflation factor in the |

| | |
|---|---|
| | Division of Rate Setting's rules to account for the increased inflation in nursing care costs since the beginning of state fiscal year 2022. |
| Persons Affected: | The rule affects the the Agency of Human Services and two of its constituent departments: DVHA and the Department of Disabilities, Aging, and Independent Living. The rule also affects all nursing homes that accept Vermont Medicaid for payment. |
| Economic Impact: | The rule will provide financial support to nursing homes to alleviate the impact of increased nursing costs in the wake of the COVID-19 pandemic. |
| Posting date: | May 01,2022 |

# Hearing Information

There are not Hearings scheduled for this Rule

# Contact Information

**Information for Primary Contact**

**PRIMARY CONTACT PERSON** - A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE.

| | |
|---|---|
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**Information for Secondary Contact**

**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.


| | |
|---|---|
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SEND A COMMENT


# Keyword Information

Keywords:

Nursing home
Medicaid
Staffing
Travel nurses

Back