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Jenney Samuelson, Secretary
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Date: April 2, 2024

Re: Response to Comment from Office of Legislative Counsel and Updated Annotated Copy of Rules

On March 28th, the Agency of Human Services received an email from Jennifer Carbee, director and chief counsel of the Office of Legislative Counsel, regarding proposed rules 24P005, Private Nonmedical Institution Rules Simplification, and 24P006, Nursing Home Rule Simplification.

The Agency appreciates Director Carbee's careful review of its proposed rules packages and clarifying questions. The Agency is providing an updated "annotated" and clean copy of each rule in response to Director Carbee's comments. In this proposed rule filing, the Agency is striking the Division of Rate Setting's existing standalone rules and replacing them in the Agency's unified Health Care Administrative Rules. The "annotated" copy we are now submitting shows the rules as if they already existed in the Agency's standard Health Care Administrative Rules format, with all changes tracked.

The Agency is further taking this opportunity to address the typographical errors and legacy definitions that were preserved from the existing version of the rules in response to Director Carbee's comments.

The Agency welcomes any chance to further clarify or answer questions about these proposed rules in advance of the Committee's meeting next April 11.

Answers to Questions from Director Carbee Regarding Resident Classification

I. Nursing Home Resident Classification System

In her March 28th email, Director Carbee asked about proposed nursing home rule 5.101.1.8 (now renumbered 5.101.1.9 after correcting a typographical error). Specifically, Director Carbee asked what it means for case-mix scores to be "based on Vermont Medicaid's chosen resident classification system," the criteria for choosing a resident classification system, and how many resident classification systems exist for Vermont Medicaid to choose from.

Vermont Medicaid is transitioning from the Resource Utilization Group IV (RUG-IV) classification system to the Patient-Driven Payment Model (PDPM). No feasible alternative exists. The rule does not specify a resident classification system so that Vermont Medicaid may anticipate future federal changes to resident classification.

Vermont state law requires the Division of Rate Setting to adopt a resident classification system that "groups residents into classes according to the similarity of their assessed condition and required services." 33 V.S.A. § 905(b)(1). For many years, the Division has used the RUG-IV classification system to classify residents. The Division and Vermont nursing home providers have historically relied

on the federal Centers for Medicare and Medicaid Services (CMS) to support this system, including setting out the classifications for residents and conditions, maintaining an all-payer database of nursing home residents according to their classifications, and checking the integrity of the data that providers reported to this database. CMS announced that it would end support for RUG-IV in favor of PDPM, which it has already implemented for Medicare payments, prior to the pandemic. CMS delayed implementing this decision several times, ultimately until 2023, because many states needed to prioritize responding to the COVID-19 pandemic. However, CMS support for RUG-IV has now been withdrawn, and the Division is unable to set rates using this system. Until the Division can implement a new resident classification system, it is setting rates based on the average resident case-mix scores for the last several quarters at each facility.

Vermont Medicaid has been diligently attempting to transition away from the RUG-IV system. After CMS notified state Medicaid agencies that it would end support for the RUG-IV system, the Agency issued an RFP seeking a consultant to assist it with identifying alternatives and transitioning to a new classification system. The Agency contracted with Myers & Stauffer to perform this work. Myers & Stauffer surveyed Vermont Medicaid's nursing home rate setting system and concluded that the only feasible path for Vermont Medicaid was to transition to a system based on the federal PDPM classification system. Any other alternative would require nursing homes to categorize their residents using two different systems and enter duplicative data in both federal and state databases, potentially imposing large administrative burdens on nursing homes (which the state, through the nursing home rate setting system, may ultimately end up paying for).

The state has been delayed in developing and implementing this solution largely for reasons outside of its control. CMS refused to enter into an amended data use agreement (DUA) with Vermont Medicaid for nearly two years, and Myers & Stauffer was accordingly unable to access the federal all-payer database to begin analyzing how PDPM would differ in the Medicaid context than its Medicare implementation. Myers & Stauffer was finally granted access to this database in the summer of 2023, and Vermont Medicaid, Myers & Stauffer, and the Vermont Health Care Association have been working to ensure that transitioning to PDPM will both be a feasible solution for both the state and affected providers and ensuring that it will comply with the reimbursement objectives set out in state law.

II. Typographical Errors

Director Carbee also identified several typographical errors in both the nursing home and PNMI rules packages. Once again, the Agency appreciates Director Carbee's careful review of these rules. Many of these errors were preserved from the original rules, but this rulemaking presents an opportunity to catch and correct them. The Agency has made changes in response to each comment:

- Throughout both packages, the Agency has updated all references to the state "promulgating regulations" to instead read that the state "adopts rules." In one instance, a nursing home rule referenced duly promulgated federal regulations. The Agency did not alter this reference.
- The definition of a PNMI referred to a "health insuring organization" in an apparent attempt to capture any health insurance plan provider or similar entity. The Agency altered this definition to refer to "a health insurer."

- The Agency removed outdated statutory references to “33 V.S.A. Chapter 3” and “18 V.S.A. § 2403.”
- The Agency updated the definition of a “hold day” as Director Carbee recommended.
- The Agency updated all references to “nurse aides” to “nurse assistants.”
- The Agency updated the assigned numbers of all subsections of proposed rule 5.101.1.

In addition to the typographical errors Director Carbee identified, the Agency corrected multiple instances where a section ended in multiple periods in both rule packages.

Methods, Standards and Principles for Establishing
Payment Rates for Private Nonmedical Institutions
Providing Residential Child Care Services

5.102 Definitions (*note*: previous rule existed at V.P.N.M.I.R. 13)

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

AICPA means the American Institute of Certified Public Accountants.

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

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

AOE means the Vermont Agency of Education.

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

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

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

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

Common Control is when 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 is where an individual or organization owns or has equity in both a facility and an institution or organization providing services to the facility.

Contract Period means the twelve month period covered by the provider contract.

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

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

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

DMH means the Department of Mental Health.

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

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

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

FASB means the Financial Accounting Standards Board.

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

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

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

Funding Application means a cost report prepared by the provider in accordance with instructions and on forms prescribed by the Division.

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

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

Health Care Cost Service means a publication by Global Insight, Inc. of national forecasts of hospital, nursing home market basket, home health agency market basket and regional forecasts of consumer price indexes.

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

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

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

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

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

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

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

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

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

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

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

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

Rate Year means the State's fiscal year ending June 30.

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

Resident means an individual who is receiving services in a PNMI.

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

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

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

Secretary means the Secretary of the Agency of Human Services.

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

5.102.1 General Provisions

5.102.1.1 Scope and Purpose

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

5.102.1.2 Authority

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

5.102.1.3 General Description of the Rate Setting System

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

5.102.1.4 Requirements for Participation in Medicaid Program

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

5.102.1.5 Prior Authorization of Placement

To receive payment under these rules from the State or a political subdivision of the State, at least one PAD must give prior authorization for any admission. ~~Prior authorization by a PAD is required for all admissions to residential treatment programs for which payment is anticipated from the State or a political subdivision thereof.~~

5.102.1.6 Responsibilities of Owners

~~The owner of a residential treatment program shall~~ Owners must prudently manage and operate a program of adequate quality to meet ~~its~~ each program's residents' needs. Owners must comply with these rules, the Private Nonmedical Institution Provider Manual, and the rules ~~and regulations~~ or other requirements and standards of the Agency of Human Services and the Agency of Education, including the Department for Children and Families' Licensing Regulations for Residential Treatment Programs. ~~Neither the issuance of a per diem rate, nor final orders made by the Director or a duly authorized representative of a PAD shall in any way relieve the owner of such a program from full responsibility for such compliance.~~ Regardless of the per diem rate set by the Division, or any other orders made by the Director, the Commissioner, the Secretary, or the PADs, the owner of such a program must comply with all applicable rules and manuals.

5.102.1.7 Duties of the Owner

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

(a) Comply with the provisions of these rules, the Private Nonmedical Institution Provider Manual, and all applicable state and federal laws and rules ~~subsections 1.4, 1.5 and 1.6 setting forth the requirements for participation in the Medicaid program~~.

(b) Submit master file documents, funding applications and supporting documentation in accordance with the provisions of ~~subsections 3.1 and 3.2~~ sections 5.102.3.1 and 5.102.3.2 of these rules and the Private Nonmedical Institution Provider Manual.

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

(d) Assure that an annual audit is performed by an independent public accountant in conformance with Generally Accepted Auditing Standards (GAAS), including a sub-schedule, when applicable, showing total PNMI revenues and costs, including allocated costs, and showing PNMI net program revenues.

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

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

5.102.1.8 Powers and Duties of the Division of Rate Setting and the Director

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

(b) The Division may require any residential treatment program or related party or organization to file such relevant and appropriate data, statistics, schedules or information as the Division finds necessary to enable it to carry out its rate setting function.

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

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

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

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

(g) The Division shall prescribe procedures and forms to be used in the completion of time studies.

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

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

(j) Neither the Division nor the PADs shall be bound in determining the allowability of reported costs, in ruling on applications for rate adjustments, or in making any other decision relating to the establishment of rates, by any prior decision. Such decisions shall have no precedential value. Principles and decisions of general applicability shall be ~~issued as a Division practice or procedure, pursuant to section 5.102.1.8(d)~~ included in the Private Nonmedical Institution Provider Manual.

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

(l) The Director shall issue, amend, and enforce the Private Nonmedical Institution Provider Manual.

5.102.1.9 Powers and Duties of the Department for Children and Families, Department of Mental Health, Agency of Education, Department of Disabilities, Aging, and Independent Living, and other Placement Authorizing Departments

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

(b) The PADs reserve the right to review, modify, accept or reject any adjustment requests made in accordance with ~~Sections 8 and 9~~ sections 5.102.8 and 5.102.9 of these rules.

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

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

(a) When computing time under these rules or the Private Nonmedical Institution Provider Manual, the day of the act or event that begins a period of time shall not be included in that period. The last day of the period of time shall be included, unless it is a Saturday, Sunday, or state or federal legal holiday, in which case the period runs until the next business day~~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) The addressee of any notice or document issued by the Division is rebuttably presumed to have received the notice or document three days after the date on the document. ~~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) The Division may extend a period of time set in these rules or the Private Nonmedical Institution Provider Manual with or without motion or notice for good cause. ~~When by these rules or by a notice given thereunder, an act is required or allowed to be done at or within a specified time, the relevant administrative officer, for just cause shown, may at any time in her or his discretion, with or without motion or notice, order the period enlarged.~~

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

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

5.102.1.11 Representation in All Matters Before the Division of Rate Setting

A provider may be represented in any matter under this rule as described in the Private Nonmedical Institution Provider Manual.

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

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

5.102.1.12 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.

5.102.1.13 Effective Date

These rules are effective from July 25, 1995 (as amended ~~August 1, 1999, August 1, 2003, August 5, 2008, February 24, 2014, September 8, 2015, July 1, 2023, and XXXX XX, 2024~~July 1, 2024).

5.102.2 Accounting Requirements

5.102.2.1 Accounting Principles

(a) All financial and statistical reports shall be prepared in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied, unless these rules or the Private Nonmedical Institution Provider Manual authorize specific variations from such principles.

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

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

5.102.2.2 Procurement Standards

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

~~(a) Providers shall establish and maintain standards governing the performance of their employees engaged in purchasing goods and services. Such standards shall provide, to the maximum extent practical, open and free competition among vendors.~~

~~(b) Any purchase that fails to satisfy the prudent buyer principle in CMS Publication 15 §2103 is subject to a disallowance.~~

5.102.2.3 Cost Allocations

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

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

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

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

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

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

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

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

5.102.2.4 Substance Over Form

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

Private Nonmedical Institution Provider Manual. ~~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.~~

5.102.2.5 Record Keeping and Retention of Records

(a) Each provider must maintain complete documentation~~, including accurate financial, medical, and statistical records, to substantiate the data reported on the funding application and on prior year's funding applications~~ of all records that substantiate the data that the provider reports to the Division. ~~and shall, upn request, make these records~~ Each provider must make all records described in this section available to the Vermont Agency of Human Services, ~~and~~ the United States Department of Health and Human Services, and any authorized representative of those 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 charge schedule and amounts of income received by service, or any other record which is necessary to provide the Director with the highest degree of confidence in the reliability of the claim for reimbursement. For purposes of this definition, affiliated entities shall extend to realty, management and other entities for which any reimbursement is directly or indirectly claimed whether or not they fall within the definition of related parties.

(c) The provider shall retain all such records for at least four years after final payment is received and all pending matters are closed.

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

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

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

5.102.3 Financial Reporting

5.102.3.1 Repealed~~Master File~~

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

~~(a) Description of current ownership structure, including copies of the articles of incorporation and bylaws,~~

~~(b) description of plant layout,~~

~~(c) current list of the board of directors,~~

~~(d) personnel policies, and~~

~~(e) such other documents or information as the Director may require.~~

5.102.3.2 Funding Application and Financial Reporting

(a) ~~Funding applications and supporting documentation for services provided by these facilities shall be reported on forms prescribed by the Director pursuant to Section 1.8.~~ The Director shall prescribe forms for funding applications and supporting documentation for services provided by PNMIs. Providers shall use these forms to submit funding applications annually or upon request.

(b) ~~The funding application must include the certification page signed by the owner or the program's representative, if authorized in writing by the owner.~~ When a provider submits a funding application, the funding application must include a certification page signed by the owner or the program's authorized representative.~~.~~

(c) ~~The original signed funding application must be submitted to the Division. The original document must bear an original signature. The funding application must also be submitted to the Division in electronic format as prescribed by the Director.~~ Providers must submit an original funding application bearing an original signature. Providers must also submit an electronic copy of the funding application in a format prescribed by the Director.

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

audited financial statements for the PNMI program. If the PNMI program is only one part of a provider's operations, these audited financial statements must include a sub-schedule showing total PNMI revenues and costs, including allocated costs, and showing PNMI net program revenues.

(e) ~~A provider~~ Providers must also submit, upon request during the desk review or audit process, such data, statistics, schedules or other information which the Division requires in order to carry out its function, including, but not limited to:

(1) current program narrative including description of treatment milieu,

(2) depreciation schedule,

(3) post-audit adjusted trial balance, including assets, liabilities, retained earnings, revenues, and expenses,

(4) list of all related parties to the program and disclosure of transactions with related parties,

(5) Repealed.~~chart of accounts with account descriptions~~

(6) schedules for amortization of long-term debt~~and depreciation of fixed assets~~,

(7) Repealed.~~list of vehicles used by the program along with a vehicle mileage summary, including beginning and ending odometer reading for the year and percentage of personal use,~~

(8) list of buildings used by the program, including a description of the purpose of each building and information about whether each building is owned or leased, and

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

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

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

(f) If ~~before the draft findings are issued, the provider has been specifically requested to provide certain information pursuant to~~ the Division has requested that a provider create or provide information or materials under

subsection (e) of this section, ~~and has failed~~ but the provider fails to do so, ~~such information or materials will not be admissible in any subsequent appeal taken pursuant to Section 12~~ the provider may not use that information or those materials in any appeal of the Division's decision on an application or audit.

5.102.3.3 Adequacy and Timeliness of Filing

(a) ~~The funding application and requested supporting documentation must be filed with the Division on a schedule to be prescribed by the Director~~ Providers must file a funding application and required supporting documentation on a schedule that Director prescribes.

(b) The Division may reject any funding application which does not ~~meet~~ comply with these rules or the Private Nonmedical Institution Provider Manual. In such a case, the funding application shall be deemed not filed, until refiled and in compliance with these rules and the Private Nonmedical Institution Provider Manual.

(c) The Division may grant an extension of the deadline for filing the funding application and required supporting documentation as provided by the Private Nonmedical Institution Provider Manual. ~~Extensions for filing of the funding application and requested supporting documentation beyond the prescribed deadline must be requested as follows:~~

~~(1) All requests for extension of time to file a funding application and supporting documentation must be in writing, on a form prescribed by the Director, and must be received by the Division of Rate Setting prior to the filing deadline. The provider must clearly explain the reason for the request and specify the date on which the Division will receive the information.~~

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

(d) ~~When rate setting is delayed because the funding application and supporting documentation are incomplete or untimely, or requested information is not provided in a timely manner,~~ If the Division is unable to set a provider's rate for any reason, the rate for the previous rate year shall remain in effect until the Division is able to set a rate. ~~The new rates will take effect from the first~~

~~day of the month following the Division's final order when such order results in an increase in the per diem rate.~~ Final orders resulting in an increase in the per diem rate will take effect from the first day of the month following the Division's final order. Final orders resulting in a decrease in the per diem rate~~,~~ will take effect from the first day of the rate period.

5.102.3.4 Review of Funding Applications by Division

(a) Desk Review

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

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

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

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

(b) On-site Audit

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

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

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

(c) The procedure for issuing and reviewing summaries of findings is set out in ~~Section 12~~ section 5.102.12.

5.102.3.5 Settlement of Funding Applications

A funding application is settled if there is no request for reconsideration of the Division's findings or, if such request was made, the Division has issued a final order pursuant to ~~subsection 12.3~~ section 5.102.12.3 of these rules.

5.102.4 Determination of Allowable Costs

5.102.4.1 Incorporation of Provider Reimbursement Manual

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

5.102.4.2 General Cost Principles

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

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

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

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

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

(1) direct qualified staff salaries and benefits,

(2) other direct program costs,

(3) direct program administrative costs and

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

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

5.102.4.3 Preapproval by PADs

~~Preapproval is encouraged for providers anticipating a significant increase in program expenses. Providers should obtain pre-approval from the Division, in consultation with the PADs, before making commitments to any significant increase in expenditures in the current approved program costs or future allowable costs, since such increase may affect the suitability of the program and/or the ability of the PADs to continue to purchase the program services.~~ If providers anticipate a significant increase in program expenses, they may seek preapproval from the Division prior to making commitments to increase their expenditures. Preapproved purchases shall not be subject to the cap limitation ~~pursuant to~~ in ~~subsections 7.4(b) and 7.5(c)~~ section 5.102.7.4(b) or 5.102.7.5(c) of these rules. The Division shall consult with the PADs to determine whether the costs shall be allowable in future funding applications, as the expenditure may affect the program's suitability for the PNMI program or the PADS' ability to afford the program's services. Programs shall apply for preapproval on forms prescribed by the Division.

5.102.4.4 Non-Recurring Costs

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

5.102.4.5 Property and Related Costs

Property and related costs shall be reimbursed according to the Private Nonmedical Institution Provider Manual. ~~Property and related costs include:~~

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

~~(b) interest on capital indebtedness,~~

~~(c) real estate leases and rents,~~

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

~~(e) equipment rental,~~

~~(f) fire and casualty insurance,~~

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

~~(h) repairs and maintenance.~~

5.102.4.6 Interest Expense

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

(b) The Private Nonmedical Institution Provider Manual shall define when interest expenses are necessary and proper, how providers must report interest expenses, and other reporting rules related to interest expenses. ~~"Necessary" requires that:~~

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

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

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

~~(d) "Proper" requires that:~~

~~(1) Interest be incurred at a rate not in excess of what a prudent buyer would have had to pay in the money market existing at the time the loan was made.~~

~~(2) Interest expense incurred as a result of transactions with a related party (or related parties) will be recognized if the expense would otherwise be allowable and if the following conditions are met:~~

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

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

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

~~(f) In refinancing of indebtedness the provider must demonstrate that the costs of refinancing will be less than the allowable costs of the current financing. Costs of refinancing may include accounting fees, legal fees and debt acquisition costs related to the refinancing. The interest expense related to the original loan's unpaid interest charges, to the extent that it is included in the refinanced loan's principal, shall not be allowed.~~

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

5.102.4.7 Basis of Property, Plant and Equipment

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

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

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

~~(1) purchase price,~~

~~(2) sales tax, and~~

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

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

~~(d) Any asset that has a basis of $2,000 or more and an estimated useful life of two or more years must be capitalized and depreciated in accordance with subsection 4.8.~~

5.102.4.8 Depreciation and Amortization of Property, Plant and Equipment

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

(b) Providers must compute depreciation and amortization in accordance with the Private Nonmedical Institution Provider Manual. ~~Depreciation and amortization must be computed on the straight-line method.~~

(c) The Division shall estimate the useful life of an asset in accordance with the Private Nonmedical Institution Provider Manual. ~~The estimated useful life of an asset shall be determined as follows:~~

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

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

5.102.4.9 Funding of Depreciation

The Division strongly recommends that providers use depreciation to conserve funds to replace depreciable assets and that providers coordinate capital expenditure planning with community and state agencies. The Division shall recognize depreciation in accordance with the Private Nonmedical Institution Provider Manual.~~Funding of depreciation is not required but it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciable assets, and coordinate their planning of capital expenditures with area-wide planning of community and state agencies.~~

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

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

5.102.4.10 Leasing Arrangements for Property, Plant and Equipment

The Division will recognize costs associated with leasing arrangements for property, plant, and equipment in accordance with the Private Nonmedical Institution Provider Manual. ~~Leasing arrangements for property, plant and equipment must meet the following conditions:~~

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

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

5.102.4.11 Legal and Litigation Costs

The Division shall recognize costs related to legal fees, litigation, and settlements, including costs related to challenges of the Division's decisions, in accordance with the Private Nonmedical Institution Provider Manual.

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

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

~~(c) Attorney fees and other expenses incurred by a provider in challenging decisions of the Division will be allowed based on the extent to which the provider prevails as determined by the ratio of total dollars at issue in the case to the total dollars awarded to the provider, subject to the non-recurring costs provision, Subsection 4.4.~~

5.102.4.12 Compensation of Owners, Operators, or their Relatives

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

~~(a) Facilities that have a full-time (40 hours per week minimum) executive director and/or assistant director, will not be allowed compensation for owners, operators, or their relatives who claim to provide some or all of the administrative functions required to operate the facility efficiently except in~~

~~limited and special circumstances such as those listed in paragraph (b) of this subsection.~~

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

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

~~(2) The unduplicated functions actually performed.~~

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

5.102.4.13 Management Fees and Central Office Costs

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

(b) Management fees will not be allowed for any individual owner or employee of a program or for any company owned or partially owned by any individual owner or employee of a program. However, if any individual owner or employee of a program receives management fees in lieu of salary or other compensation, the Division will apply the provisions of ~~subsection 4.21~~ section 5.102.4.21 to impute a reasonable amount of compensation that may be allowed for PNMI reimbursement for the individual owner or employee. No consulting costs or any other form of compensation shall be allowed in addition to the imputed allowable salary amount.

5.102.4.14 Advertising and Public Relations

The Division shall recognize reasonable and necessary advertising expenses in accordance with the Private Nonmedical Institution Provider Manual. ~~The following costs are not allowable:~~

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

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

5.102.4.15 Bad Debts, Charity, and Courtesy Allowances

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

5.102.4.16 Related Party

The Division shall disallow costs related to a related party expense in accordance with the Private Nonmedical Institution Provider Manual. The Division may request that the provider or a related party submit information, books, and records related to related party expenses. ~~Expenses otherwise allowable shall not be included for purposes of determining a prospective rate where such expenses are paid to a related party unless the provider identifies any such related party and the expenses attributable to it and demonstrates that such expenses are the actual cost to the related party without any markup or any additional negotiated fees. The Division may require either the provider or the related party, or both, to submit information, books and records relating to such expenses for the purpose of determining their allowability, including the related party audited financial statements.~~

5.102.4.17 Applied Revenues

The Division shall disallow costs related to revenues the facility receives for providing goods or services other than the services compensated under these rules in accordance with the Private Nonmedical Institution Provider Manual. ~~Where a program or central office of the program reports revenues other than those received from per diem rates, these revenues shall be applied to reduce the allowable direct program costs or central office allocation according to the following provisions.~~

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

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

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

5.102.4.18 Travel/Entertainment Costs

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

5.102.4.19 Transportation Costs

Costs for ambulance services for emergency transportation are covered pursuant to other rules adopted by the Agency of Human Services and are not allowable under these rules. The Division shall recognize reasonable and necessary costs related to transportation, other than costs for ambulance services for emergency transportation, in accordance with the Private Nonmedical Institution Provider Manual. ~~Costs of transportation incurred, other than ambulance services covered pursuant to the Vermont Medicaid Covered Services Rules, that are necessary and reasonable for the care of residents are allowable. Such costs shall include depreciation of vehicles, mileage reimbursement to employees for the use of their vehicles to provide transportation for residents, and any contractual arrangements for providing such transportation. Such costs shall not be separately billed for individual residents. Providers shall keep vehicle mileage logs and other similar records to track program costs for transportation.~~

5.102.4.20 Costs for New Programs and Start-Up Costs

Providers may propose new programs to be reimbursed under the PNMI model in accordance with the Private Nonmedical Institution Provider Manual.

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

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

5.102.4.21 Compensation Limitations

The Division shall set limits on allowable compensation for PNMI administrators and staff as provided in the Private Nonmedical Institution Provider Manual.

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

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

5.102.5 Classification of Costs and Assignment to Service Categories

5.102.5.1 General

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

5.102.5.2 Repealed

Repealed.

5.102.5.3 Service and Administration Categories

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

(a) Service Categories

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

(2) Education: Educational costs are those costs incurred providing academic instruction to the program residents as part of an educational

curriculum delivered or supervised by certified teaching staff. Not all programs provide approved academic services, and therefore not all facilities will have educational costs.

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

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

5.102.6 Reimbursement Standards

5.102.6.1 Prospective Reimbursement System and the Per Diem Rate

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

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

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

(d) The per diem rate payment is payment in full for all covered services for that day ~~and shall be used by all PADs to reimburse for services provided during the contract period~~ subject to the limitations in ~~Section 10~~ section 5.102.10. Billing and payment procedures shall be determined by the PADs.

(e) No separate billing may be made by the program provider or any other provider for any type of service which has been included in the approved program costs. ~~If a provider is unsure whether a type of service has been included in the approved program costs, it must refer the question to the Division which will issue a determination after consultation with the PADS.~~ Providers may inquire with the Division if they are unsure whether a service is included in its per diem rate. The Division shall issue a determination in consultation with the PADs.

5.102.6.2 Temporary Absences

~~Reimbursement may be available for temporary absences from the facility of up to fifteen days per episode in accordance with provider contract provisions, subject to preapproval by the appropriate child placement agency.~~ Providers may be reimbursed for temporary absences in accordance with their contract and the Private Nonmedical Institution Provider Manual.

5.102.6.3 Retroactive Adjustments to Prospective Rates

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

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

(1) as an adjustment pursuant to ~~Section 9~~ section 5.102.9;

(2) in response to a decision by the Secretary pursuant to ~~subsection 12.4~~ section 5.102.12.4 or to an order of a court of competent jurisdiction;

(3) for mechanical computation or typographical errors;

(4) as a result of revised findings resulting from the reopening of a settled funding application pursuant to ~~subsection 3.4(b)(2)~~ section 5.102.3.4(b)(2);

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

(6) recovery of overpayments pursuant to ~~subsection 10.1~~ section 5.102.10.1 as a result of a provider exceeding the contract maximum; or

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

5.102.6.4 Interim Rates

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

(b) Any overpayments or underpayments resulting from the difference between the interim and final rates will be either refunded by the providers or paid to the providers, unless the difference is within $1.00 for any individual service category. In such cases, the interim rate shall become the final rate, subject to section 5.102.12 of these rules.

5.102.6.5 Base Year

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

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

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

5.102.6.6 Occupancy Level

The Division shall set a minimum occupancy level for all programs according to the Private Nonmedical Institution Provider Manual. Exceptions to this level shall be granted according to the Private Nonmedical institution Provider Manual.

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

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

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

5.102.6.7 Inflation Factors

The Division shall adjust each per diem rate by an inflation factor in accordance with a procedure established in the Private Nonmedical Institution Provider Manual.

~~(a) The Division shall calculate a single annual inflation factor. The Division shall adjust each PNMI program's allowable costs used in each PNMI program's rate calculation according to this annual inflation factor.~~

~~(b) To calculate the annual inflation factor, the Division shall review the costs incurred in the most recent complete set of base year data submitted by each PNMI program. The Division shall assign each cost to one of three cost subcomponent categories:~~

~~(1) Total Salary and Contract Costs;~~

~~(2) Employee Benefits; and~~

~~(3) Other Costs.~~

~~(c) The Division shall calculate a subcomponent inflation factor for each subcomponent category. The Division shall calculate the annual inflation factor as a weighted average of the inflation factors for each subcomponent inflation factor. For example, if the total Vermont PNMI costs were comprised of 58.5% Total Salary and Contract Costs, 16.4% Employee Benefits, and 25.1% Other Costs, the weight for the Total Salary and Contract Costs inflation factor would be 0.585, the weight for the Employee Benefits inflation factor would be 0.164 and the weight for the Other Costs inflation factor would be 0.251.~~

~~(d) The Division shall use the most recent publication of the Health Care Cost Service available on January 1 prior to the July 1 start of the rate year to calculate the annual inflation factor.~~

~~(1) The Total Salary and Contract Cost inflation factor shall be calculated using the wages and salaries price index of the Health Care Cost Nursing Home Market Basket.~~

~~(2) The Employee Benefits inflation factor shall be calculated using the employee benefits price index of the Health Care Cost Nursing Home Market Basket.~~

~~(3) The Other Costs inflation factor shall be calculated using the New England consumer price index.~~

~~(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.~~

5.102.6.8 Cap on Increases from Prior Year to Current Base Year

The Division shall cap the programs' increases by calculating a maximum increase from the prior base year to the current base year pursuant to ~~this subsection~~ the Private Nonmedical Institution Provider Manual.

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

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

~~(2) The Division shall determine an uninflated occupancy adjusted per diem rate. This uninflated occupancy adjusted per diem rate will compensate for the increase in the per diem rate that occurs when a~~

lower number of resident days is used in the rate calculation. In calculating the uninflated occupancy adjusted per diem rate, the Division will use the resident days from the prior base year rate calculations. The uninflated occupancy adjusted per diem rate will be calculated as follows:

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

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

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

(3) Allowed Percentage Increase to the Uninflated Occupancy Adjusted Per Diem Rate. The table below shows the factor to be applied to the uninflated occupancy adjusted prior base year per diem rate to calculate the cap on the current year uninflated per diem rate in accordance with paragraph (a)(4). This factor is on a scale that relates

to the magnitude of the programs' prior base year allowable costs before revenue offset.

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

(4) The cap on the current year uninflated per diem rate, excluding rate adjustments, is the uninflated occupancy adjusted prior base year per diem rate calculated pursuant to paragraph (a)(2), multiplied by 100% plus the factor from the table in paragraph (a)(3). The result will be the maximum uninflated per diem rate the provider may receive for the current base year. If the uninflated calculated per diem rate exceeds the maximum uninflated allowed per diem rate, the difference will be the uninflated per diem effect of the cap. The uninflated per diem effect of the cap shall be adjusted by the annual inflation factor pursuant to subsection 6.7, and the resulting inflated per diem effect of the cap shall be subtracted from the inflated calculated per diem rate to arrive at the capped per diem rate. Existing and new rate adjustments will be added to the capped per diem rate for the total allowed per diem rate.

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

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

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

Prior Base Year Allowable Costs Before Revenue Offset	Allowed Percentage Change for Cost Increases
Up to $600,000	6.0%
$600,001 – $1,000,000	5.0%
$1,000,001 – $1,800,000	4.0%

~~$1,800,001 – $4,000,000~~	~~3.0%~~
~~Over $4,000,000~~	~~2.0%~~

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

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

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

5.102.7 Calculation of Costs, Limits and Rates for PNMI Facilities

5.102.7.1 Repealed

Repealed.

5.102.7.2 Approved Program Costs

~~The calculation of the rates shall be based on total allowable base year costs determined by the Division pursuant to these rules.~~ The Division shall calculate per diem rates using total base year costs that it has deemed allowable under these rules and the Private Nonmedical Institution Provider Manual.

5.102.7.3 Repealed

Repealed.

5.102.7.4 Repealed ~~Calculation of Per Diem Rate~~

Repealed.

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

~~(b) The Division shall adjust each program's allowable costs by applying an annual inflation factor pursuant to subsection 6.7.~~

~~(c) The Division shall limit the current rate period's per diem rate by the cap calculated pursuant to subsection 6.8.~~

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

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

5.102.7.5 Calculation of Per Diem Rates for Crisis/Stabilization Programs

The PADs may designate a program with a typical length of stay from 0 to 10 days as a crisis or stabilization program. The Division shall calculate per diem rates for these programs each month in accordance with the Private Nonmedical Institution Provider Manual. ~~For programs categorized by the PADs as crisis/stabilization programs with typical lengths of stay from 0 – 10 days, rates are set retroactively as follows:~~

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

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

~~(c) The Division shall limit increases from year to year in total allowable base year costs of crisis/stabilization programs by the cap calculated pursuant to subsection 6.8(b).~~

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

5.102.7.6 Recapture of Net PNMI Revenue in Excess of Five Percent

The Division shall recapture PNMI profit in accordance with the Private Nonmedical Institution Provider Manual. ~~The Division will review programs' audited financial statements and will recapture PNMI profit by applying the net revenue in excess of five percent against the current year's total allowable costs. The calculation of the recapture of net PNMI revenue in excess of five percent shall take into consideration the effect of the cap in subsection 6.8. Any amounts of revenue offset which are greater than the effect of the cap will be offset.~~

5.102.7.7 Calculation of Per Diem Rate for Programs that Do Not Provide Room and Board

The Division shall calculate a per diem rate using total base year costs that it has deemed allowable for programs that do not provide room and board under the Private Nonmedical Institution Provider Manual.

5.102.7.8 Calculation of Per Diem Rate for Programs that Provide Room and Board to Individuals and their Children

The Division shall calculate a per diem rate using total base year costs that it has deemed allowable for programs that treat individuals but must provide room and board for both the individual and their children to receive reimbursement under the Private Nonmedical Institution Provider Manual.

5.102.8 Adjustments to Rates

5.102.8.1 Procedures and Requirements for Rate Adjustments

Providers may apply for rate adjustments during the rate year. ~~Applications for rate adjustments pursuant to this section shall be made as follows.~~

(a) ~~Application for a Rate Adjustment shall be made on a form prescribed by the Director and filed with the Division and shall be accompanied by all documents and proofs determined necessary for the Division to make an informed decision.~~ The Division shall prescribe forms for rate adjustments and require all documents or other evidence necessary for the Division to make a decision on the application.

(b) ~~No adjustment shall be made which would result in payments exceeding any limits set out in these rules or in the provider contract.~~ The Division shall not grant a rate adjustment that would result in payments exceeding any limits set out in these rules or the Private Nonmedical Institution Provider Manual or in the provider contract.

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

(d) Providers may apply for a rate adjustment for one or more of the following reasons:

(1) The provider must increase their expenditures because a PAD has required the program to change their operations. The PAD must confirm to the Division in writing that it has required the program to change its operations. The provider must explain why the required change has caused an increase in expenditures.

(2) The provider must increase their expenditures to correct a deficiency identified by a law enforcement agency, a public health agency, or an agency that licenses their operations.

(3) The provider has incurred costs to respond to an emergency, such as a fire, flood, pandemic, or other disaster outside the control of the provider or PADs.

(4) The provider must increase their expenditures because of circumstances that were not foreseeable by the provider or the PADs at the time the rate was set.

5.102.8.2 Approval of Applications

(a) The burden of proof is at all times on the provider to show that the conditions for which the adjustment has been requested are reasonable, necessary and related to resident care, and ~~are the result of required program changes or true emergencies or circumstances that were not foreseeable at the time the current rate was set.~~ meet one of the four grounds identified in section 5.102.8.1(d) of these rules.

(b) ~~Approval of any application for a rate adjustment under this section is at the sole discretion of the Director in consultation with designees representing the PADs. The Division may grant or deny the application, or make an adjustment modifying the provider's proposal.~~ The Director, in consultation with the PADs, shall approve or deny a rate adjustment in her sole discretion. The Director may grant or deny the application in whole or in part. If the materials filed by the provider are inadequate to serve as a basis for a reasonable decision, the Division shall deny the application, unless additional proofs are submitted. Once the Division has deemed the application complete, the Division will issue its findings within 30 days.

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

(d) In the event that a rate adjustment is approved, the new rate will be effective for service provided from the first day of the month in which the draft findings and order were issued or following the date the assets are actually put into service or expenses incurred, whichever is later.

(e) Approved rate adjustments will not be subject to the cap limitation pursuant to ~~subsection 6.8~~ section 5.102.6.8.

5.102.8.3 Limitations on Availability of Rate Adjustments

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

5.102.9 Extraordinary Financial Relief

~~Extraordinary financial relief may be available, at the discretion of the PADS, for a provider that the Division determines to be experiencing demonstrable and temporary financial difficulties.~~ To protect residents from the closing of a PNMI program in which they reside, this section establishes a process for PNMIs experiencing demonstrable and temporary financial difficulties to seek extraordinary financial relief. This provision does not create any entitlement to a rate in excess of that which the provider would receive under the normal operation of these rules or to any other form of relief.

(a) The PADs shall grant extraordinary financial relief in their sole discretion. Based on the individual circumstances of each case, the PADs may authorize extraordinary financial relief based on any one or a combination of the following: exemption of a program from the minimum occupancy guidelines, retroactive implementation of a rate adjustment at an earlier point in the rate period, increase in approved program costs, or such other relief as the PADs may find appropriate. The PADs may impose any conditions they find appropriate on this relief, including financial, managerial, quality, operational, or other changes. If a program declines to meet these conditions, the PADs may decline to grant extraordinary financial relief.

(b) ~~After the end of the contract period, the Division shall review rates set pursuant to this subsection to determine whether revenues during the contract period exceeded the approved program costs. To the extent that revenues exceed the approved program costs for the contract period, the Division shall apply such excess against the program's costs for the current period pursuant to V.P.N.M.I.R. §7.6, except that no allowance shall be made for excess revenues of up to five percent, and all excess revenues shall be applied~~ If the PADs grant extraordinary financial relief under this section, the Division shall recover all revenues that exceed approved program costs by applying any excess revenue against the rate the Division set for the program's next contract period unless, and only to the extent that, the Division determines that recovering excess revenues would create further financial difficulties.

(c) ~~Procedure - An application for extraordinary financial relief shall be in writing and filed with the Division. It shall be supported by such documentation as the Division may require. The burden of proof is at all times on the provider. If the materials filed by the provider are inadequate to serve as a basis for a reasoned decision, the application shall be denied, unless additional proofs are submitted.~~ Providers shall apply for extraordinary financial relief in writing and file their applications with the Division, supported by any documentation the Division requires to substantiate it. It is the provider's burden to prove that

the provider is experiencing demonstrable and temporary financial difficulties. If the materials filed by the provider are inadequate to serve as a basis for a reasoned decision, the application shall be denied, unless additional proofs are submitted.

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

5.102.10 Limitations on Payments

5.102.10.1 Contract Maximum

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

5.102.10.2 Upper Payment Limits

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

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

5.102.10.3 Lower of Rate or Charges

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

5.102.11 Payment for Interstate Placements

5.102.11.1 Out-of-State Services

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

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

5.102.11.2 In-State Services for Out-of-State Authorities

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

5.102.12 Administrative Review and Appeals

5.102.12.1 Draft Findings and Decisions

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

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

5.102.12.2 Request for an Informal Conference on Draft Findings and Decisions

(a) Within 15 days of receipt of either the draft findings or decision or requested work papers, whichever is the later, a provider that is dissatisfied with the draft findings or decision issued pursuant to ~~subsection 12.1(a)~~ section 5.102.12.1(a) may file a written request for an informal conference with the Division's staff on a form prescribed by the Director.

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

(c) A request for an informal conference must be pursued before a request for reconsideration can be filed pursuant to ~~subsection 12.3~~ section 5.102.12.3.

(d) Should no timely request for an informal conference be filed within the time period specified in ~~subsection 12.2(a)~~ section 5.102.12.2(a), the Division's draft findings and/or decision are final and no longer subject to administrative review or judicial appeal.

(e) Should a provider request an informal conference, but fail to raise an issue in the request for the informal conference, the provider may not raise that issue

in the informal conference or in any subsequent proceeding arising from the same action of the Division.

5.102.12.3 Request for Reconsideration

(a) A provider that is aggrieved by an official action issued pursuant to ~~subsection 12.2(b)~~ section 5.102.12.2(b) may file a request for reconsideration.

(b) The request for reconsideration must be in writing, on a form prescribed by the Director, and filed within 30 days of the provider's receipt of the official action. Should no timely request for an informal conference be filed within the time period specified in this paragraph, the official action issued pursuant to ~~subsection 12.2(b)~~ section 5.102.12.2(b) is final and no longer subject to administrative review or judicial appeal.

(c) The request for reconsideration shall include the following:

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

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

(d) Issues not raised in the request for reconsideration shall not be raised later in this proceeding or in any subsequent proceeding arising from the same action of the Division.

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

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

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

5.102.12.4 Request for Administrative Review

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

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

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

5.102.12.5 General Provisions

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

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

Methods, Standards and Principles for Establishing
Payment Rates for Private Nonmedical Institutions
Providing Residential Child Care Services

5.102 Definitions

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

AICPA means the American Institute of Certified Public Accountants.

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

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

AOE means the Vermont Agency of Education.

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

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

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

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

Common Control is when 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 is where an individual or organization owns or has equity in both a facility and an institution or organization providing services to the facility.

Contract Period means the twelve month period covered by the provider contract.

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

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

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

DMH means the Department of Mental Health.

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

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

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

FASB means the Financial Accounting Standards Board.

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

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

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

Funding Application means a cost report prepared by the provider in accordance with instructions and on forms prescribed by the Division.

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

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

Health Care Cost Service means a publication by Global Insight, Inc. of national forecasts of hospital, nursing home market basket, home health agency market basket and regional forecasts of consumer price indexes.

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

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

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

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

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

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

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

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

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

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

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

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

Rate Year means the State's fiscal year ending June 30.

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

Resident means an individual who is receiving services in a PNMI.

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

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

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

Secretary means the Secretary of the Agency of Human Services.

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

5.102.1 General Provisions

5.102.1.1 Scope and Purpose

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

5.102.1.2 Authority

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

5.102.1.3 General Description of the Rate Setting System

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

5.102.1.4 Requirements for Participation in Medicaid Program

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

5.102.1.5 Prior Authorization of Placement

To receive payment under these rules from the State or a political subdivision of the State, at least one PAD must give prior authorization for any admission.

5.102.1.6 Responsibilities of Owners

Owners must prudently manage and operate a program of adequate quality to meet each program's residents' needs. Owners must comply with these rules, the Private Nonmedical Institution Provider Manual, and the rules or other requirements and stan-

dards of the Agency of Human Services and the Agency of Education, including the Department for Children and Families' Licensing Regulations for Residential Treatment Programs. Regardless of the per diem rate set by the Division, or any other orders made by the Director, the Commissioner, the Secretary, or the PADs, the owner of such a program must comply with all applicable rules and manuals.

5.102.1.7 Duties of the Owner

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

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

(b) Submit master file documents, funding applications and supporting documentation in accordance with the provisions of sections 5.102.3.1 and 5.102.3.2 of these rules and the Private Nonmedical Institution Provider Manual.

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

(d) Assure that an annual audit is performed by an independent public accountant in conformance with Generally Accepted Auditing Standards (GAAS), including a sub-schedule, when applicable, showing total PNMI revenues and costs, including allocated costs, and showing PNMI net program revenues.

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

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

5.102.1.8 Powers and Duties of the Division of Rate Setting and the Director

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

(b) The Division may require any residential treatment program or related party or organization to file such relevant and appropriate data, statistics, schedules or information as the Division finds necessary to enable it to carry out its rate setting function.

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

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

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

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

(g) The Division shall prescribe procedures and forms to be used in the completion of time studies.

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

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

(j) Neither the Division nor the PADs shall be bound in determining the allowability of reported costs, in ruling on applications for rate adjustments, or in making any other decision relating to the establishment of rates, by any prior decision. Such decisions shall have no precedential value. Principles and decisions of general applicability shall be included in the Private Nonmedical Institution Provider Manual.

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

(l) The Director shall issue, amend, and enforce the Private Nonmedical Institution Provider Manual.

5.102.1.9 Powers and Duties of the Department for Children and Families, Department of

Mental Health, Agency of Education, Department of Disabilities, Aging, and Independent Living, and other Placement Authorizing Departments

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

(b) The PADs reserve the right to review, modify, accept or reject any adjustment requests made in accordance with sections 5.102.8 and 5.102.9 of these rules.

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

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

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

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

(c) The Division may extend a period of time set in these rules or the Private Nonmedical Institution Provider Manual with or without motion or notice for good cause.

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

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

5.102.1.11 Representation in All Matters Before the Division of Rate Setting

A provider may be represented in any matter under this rule as described in the Private Nonmedical Institution Provider Manual.

5.102.1.12 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.

5.102.1.13 Effective Date

These rules are effective from July 25, 1995 (as amended July 1, 2024).

5.102.2 Accounting Requirements

5.102.2.1 Accounting Principles

(a) All financial and statistical reports shall be prepared in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied, unless these rules or the Private Nonmedical Institution Provider Manual authorize specific variations from such principles.

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

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

5.102.2.2 Procurement Standards

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

5.102.2.3 Cost Allocations

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

5.102.2.4 Substance Over Form

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

5.102.2.5 Record Keeping and Retention of Records

(a) Each provider must maintain complete documentation of all records that substantiate the data that the provider reports to the Division. Each provider must make all records described in this section available to the Vermont Agency of Human Services, the United States Department of Health and Human Services, and any authorized representative of those 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 charge schedule and amounts of income received by service, or any other record which is necessary to provide the Director with the highest degree of confidence in the reliability of the claim for reimbursement. For purposes of this definition, affiliated entities shall extend to realty, management and other entities for which any reimbursement is directly or indirectly claimed whether or not they fall within the definition of related parties.

(c) The provider shall retain all such records for at least four years after final payment is received and all pending matters are closed.

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

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

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

5.102.3 Financial Reporting

5.102.3.1 Repealed

Repealed.

5.102.3.2 Funding Application and Financial Reporting

(a) The Director shall prescribe forms for funding applications and supporting documentation for services provided by PNMIs. Providers shall use these forms to submit funding applications annually or upon request.

(b) When a provider submits a funding application, the funding application must include a certification page signed by the owner or the program's authorized representative.

(c) Providers must submit an original funding application bearing an original signature. Providers must also submit an electronic copy of the funding application in a format prescribed by the Director.

(d) When submitting a funding application, providers must also submit audited financial statements for the PNMI program. If the PNMI program is only one part of a provider's operations, these audited financial statements must include a sub-schedule showing total PNMI revenues and costs, including allocated costs, and showing PNMI net program revenues.

(e) Providers must also submit, upon request during the desk review or audit process, such data, statistics, schedules or other information which the Division requires in order to carry out its function, including, but not limited to:

(1) current program narrative including description of treatment milieu,

(2) depreciation schedule,

(3) post-audit adjusted trial balance, including assets, liabilities, retained earnings, revenues, and expenses,

(4) list of all related parties to the program and disclosure of transactions with related parties,

(5) Repealed.

(6) schedules for amortization of long-term debt,

(7) Repealed.

(8) list of buildings used by the program, including a description of the purpose of each building and information about whether each building is owned or leased, and

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

(10) Repealed.

(11) Repealed.

(f) If the Division has requested that a provider create or provide information or materials under subsection (e) of this section, but the provider fails to do so, the provider may not use that information or those materials in any appeal of the Division's decision on an application or audit.

5.102.3.3 Adequacy and Timeliness of Filing

(a) Providers must file a funding application and required supporting documentation on a schedule that Director prescribes.

(b) The Division may reject any funding application which does not comply with these rules or the Private Nonmedical Institution Provider Manual. In such a case, the funding application shall be deemed not filed, until refiled and in compliance with these rules and the Private Nonmedical Institution Provider Manual.

(c) The Division may grant an extension of the deadline for filing the funding application and required supporting documentation as provided by the Private Nonmedical Institution Provider Manual.

(d) If the Division is unable to set a provider's rate for any reason, the rate for the previous rate year shall remain in effect until the Division is able to set a rate. Final orders resulting in an increase in the per diem rate will take effect from the first day of the month following the Division's final order. Final orders

resulting in a decrease in the per diem rate will take effect from the first day of the rate period.

5.102.3.4 Review of Funding Applications by Division

(a) Desk Review

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

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

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

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

(b) On-site Audit

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

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

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

(c) The procedure for issuing and reviewing summaries of findings is set out in section 5.102.12.

5.102.3.5 Settlement of Funding Applications

A funding application is settled if there is no request for reconsideration of the Division's findings or, if such request was made, the Division has issued a final order pursuant to section 5.102.12.3 of these rules.

5.102.4 Determination of Allowable Costs

5.102.4.1 Incorporation of Provider Reimbursement Manual

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

5.102.4.2 General Cost Principles

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

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

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

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

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

(1) direct qualified staff salaries and benefits,

(2) other direct program costs,

(3) direct program administrative costs and

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

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

5.102.4.3 Preapproval by PADs

If providers anticipate a significant increase in program expenses, they may seek preapproval from the Division prior to making commitments to increase their expenditures. Preapproved purchases shall not be subject to the cap limitation in section 5.102.7.4(b) or 5.102.7.5(c) of these rules. The Division shall consult with the PADs to determine whether the costs shall be allowable in future funding applications, as the expenditure may affect the program's suitability for the PNMI program or the PADS' ability to afford the program's services. Programs shall apply for preapproval on forms prescribed by the Division.

5.102.4.4 Non-Recurring Costs

Non-recurring costs shall be capitalized and amortized as described in the Private Nonmedical Institution Provider Manual.

5.102.4.5 Property and Related Costs

Property and related costs shall be reimbursed according to the Private Nonmedical Institution Provider Manual.

5.102.4.6 Interest Expense

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

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

5.102.4.7 Basis of Property, Plant and Equipment

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

5.102.4.8 Depreciation and Amortization of Property, Plant and Equipment

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

(b) Providers must compute depreciation and amortization in accordance with the Private Nonmedical Institution Provider Manual.(c) The Division shall estimate the useful life of an asset in accordance with the Private Nonmedical Institution Provider Manual.

5.102.4.9 Funding of Depreciation

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

5.102.4.10 Leasing Arrangements for Property, Plant and Equipment

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

5.102.4.11 Legal and Litigation Costs

The Division shall recognize costs related to legal fees, litigation, and settlements, including costs related to challenges of the Division's decisions, in accordance with the Private Nonmedical Institution Provider Manual.

5.102.4.12 Compensation of Owners, Operators, or their Relatives

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

5.102.4.13 Management Fees and Central Office Costs

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

(b) Management fees will not be allowed for any individual owner or employee of a program or for any company owned or partially owned by any individual owner or employee of a program. However, if any individual owner or employee of a program receives management fees in lieu of salary or other compensation, the Division will apply the provisions of section 5.102.4.21 to impute a reasonable amount of compensation that may be allowed for PNMI

reimbursement for the individual owner or employee. No consulting costs or any other form of compensation shall be allowed in addition to the imputed allowable salary amount.

5.102.4.14 Advertising and Public Relations

The Division shall recognize reasonable and necessary advertising expenses in accordance with the Private Nonmedical Institution Provider Manual.

5.102.4.15 Bad Debts, Charity, and Courtesy Allowances

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

5.102.4.16 Related Party

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

5.102.4.17 Applied Revenues

The Division shall disallow costs related to revenues the facility receives for providing goods or services other than the services compensated under these rules in accordance with the Private Nonmedical Institution Provider Manual.

5.102.4.18 Travel/Entertainment Costs

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

5.102.4.19 Transportation Costs

Costs for ambulance services for emergency transportation are covered pursuant to other rules adopted by the Agency of Human Services and are not allowable under these rules. The Division shall recognize reasonable and necessary costs related to transportation, other than costs for ambulance services for emergency transportation, in accordance with the Private Nonmedical Institution Provider Manual.

5.102.4.20 Costs for New Programs and Start-Up Costs

Providers may propose new programs to be reimbursed under the PNMI model in accordance with the Private Nonmedical Institution Provider Manual.

5.102.4.21 Compensation Limitations

The Division shall set limits on allowable compensation for PNMI administrators and staff as provided in the Private Nonmedical Institution Provider Manual.

5.102.5 Classification of Costs and Assignment to Service Categories

5.102.5.1 General

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

5.102.5.2 Repealed

Repealed.

5.102.5.3 Service and Administration Categories

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

(a) Service Categories

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

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

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

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

5.102.6 Reimbursement Standards

5.102.6.1 Prospective Reimbursement System and the Per Diem Rate

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

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

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

(d) The per diem rate payment is payment in full for all covered services for that day subject to the limitations in section 5.102.10. Billing and payment procedures shall be determined by the PADs.

(e) No separate billing may be made by the program provider or any other provider for any type of service which has been included in the approved program costs. Providers may inquire with the Division if they are unsure whether a service is included in its per diem rate. The Division shall issue a determination in consultation with the PADs.

5.102.6.2 Temporary Absences

Providers may be reimbursed for temporary absences in accordance with their contract and the Private Nonmedical Institution Provider Manual.

5.102.6.3 Retroactive Adjustments to Prospective Rates

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

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

(1) as an adjustment pursuant to section 5.102.9;

(2) in response to a decision by the Secretary pursuant to section 5.102.12.4 or to an order of a court of competent jurisdiction;

(3) for mechanical computation or typographical errors;

(4) as a result of revised findings resulting from the reopening of a settled funding application pursuant to section 5.102.3.4(b)(2);

(5) recovery of overpayments or other adjustments as required by law or duly adopted rule;

(6) recovery of overpayments pursuant to section 5.102.10.1 as a result of a provider exceeding the contract maximum; or

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

5.102.6.4 Interim Rates

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

(b) Any overpayments or underpayments resulting from the difference between the interim and final rates will be either refunded by the providers or paid to the providers, unless the difference is within $1.00 for any individual service category. In such cases, the interim rate shall become the final rate, subject to section 5.102.12 of these rules.

5.102.6.5 Base Year

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

(b) All costs shall be rebased every July 1.

(c) Repealed.

5.102.6.6 Occupancy Level

The Division shall set a minimum occupancy level for all programs according to the Private Nonmedical Institution Provider Manual. Exceptions to this level shall be granted according to the Private Nonmedical institution Provider Manual.

5.102.6.7 Inflation Factors

The Division shall adjust each per diem rate by an inflation factor in accordance with a procedure established in the Private Nonmedical Institution Provider Manual.

5.102.6.8 Cap on Increases from Prior Year to Current Base Year

The Division shall cap the programs' increases by calculating a maximum increase from the prior base year to the current base year pursuant to the Private Nonmedical Institution Provider Manual.

5.102.7 Calculation of Costs, Limits and Rates for PNMI Facilities

5.102.7.1 Repealed

Repealed.

5.102.7.2 Approved Program Costs

The Division shall calculate per diem rates using total base year costs that it has deemed allowable under these rules and the Private Nonmedical Institution Provider Manual.

5.102.7.3 Repealed

Repealed.

5.102.7.4 Repealed

Repealed.

5.102.7.5 Calculation of Per Diem Rates for Crisis/Stabilization Programs

The PADs may designate a program with a typical length of stay from 0 to 10 days as a crisis or stabilization program. The Division shall calculate per diem rates for these programs each month in accordance with the Private Nonmedical Institution Provider Manual.

5.102.7.6 Recapture of Net PNMI Revenue in Excess of Five Percent

The Division shall recapture PNMI profit in accordance with the Private Nonmedical Institution Provider Manual.

5.102.7.7 Calculation of Per Diem Rate for Programs that Do Not Provide Room and Board

The Division shall calculate a per diem rate using total base year costs that it has deemed allowable for programs that do not provide room and board under the Private Nonmedical Institution Provider Manual.

5.102.7.8 Calculation of Per Diem Rate for Programs that Provide Room and Board to Individuals and their Children

The Division shall calculate a per diem rate using total base year costs that it has deemed allowable for programs that treat individuals but must provide room and board for both the individual and their children to receive reimbursement under the Private Nonmedical Institution Provider Manual.

5.102.8 Adjustments to Rates

5.102.8.1 Procedures and Requirements for Rate Adjustments

Providers may apply for rate adjustments during the rate year.

(a) The Division shall prescribe forms for rate adjustments and require all documents or other evidence necessary for the Division to make a decision on the application.

(b) The Division shall not grant a rate adjustment that would result in payments exceeding any limits set out in these rules or the Private Nonmedical Institution Provider Manual or in the provider contract.

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

(d) Providers may apply for a rate adjustment for one or more of the following reasons:

(1) The provider must increase their expenditures because a PAD has required the program to change their operations. The PAD must confirm to the Division in writing that it has required the program to change its operations. The provider must explain why the required change has caused an increase in expenditures.

(2) The provider must increase their expenditures to correct a deficiency identified by a law enforcement agency, a public health agency, or an agency that licenses their operations.

(3) The provider has incurred costs to respond to an emergency, such as a fire, flood, pandemic, or other disaster outside the control of the provider or PADs.

(4) The provider must increase their expenditures because of circumstances that were not foreseeable by the provider or the PADs at the time the rate was set.

5.102.8.2 Approval of Applications

(a) The burden of proof is at all times on the provider to show that the conditions for which the adjustment has been requested are reasonable, necessary and related to resident care, and meet one of the four grounds identified in section 5.102.8.1(d) of these rules.

(b) The Director, in consultation with the PADs, shall approve or deny a rate adjustment in her sole discretion. The Director may grant or deny the application in whole or in part. If the materials filed by the provider are inadequate to serve as a basis for a reasonable decision, the Division shall deny the application, unless additional proofs are submitted. Once the Division has deemed the application complete, the Division will issue its findings within 30 days.

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

(d) In the event that a rate adjustment is approved, the new rate will be effective for service provided from the first day of the month in which the draft findings and order were issued or following the date the assets are actually put into service or expenses incurred, whichever is later.

(e) Approved rate adjustments will not be subject to the cap limitation pursuant to section 5.102.6.8.

5.102.8.3 Limitations on Availability of Rate Adjustments

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

5.102.9 Extraordinary Financial Relief

To protect residents from the closing of a PNMI program in which they reside, this section establishes a process for PNMIs experiencing demonstrable and temporary financial difficulties to seek extraordinary financial relief. This provision does not create any entitlement to a rate in excess of that which the provider would receive under the normal operation of these rules or to any other form of relief.

(a) The PADs shall grant extraordinary financial relief in their sole discretion. Based on the individual circumstances of each case, the PADs may authorize extraordinary financial relief based on any one or a combination of the following: exemption of a program from the minimum occupancy guidelines,

retroactive implementation of a rate adjustment at an earlier point in the rate period, increase in approved program costs, or such other relief as the PADs may find appropriate. The PADs may impose any conditions they find appropriate on this relief, including financial, managerial, quality, operational, or other changes. If a program declines to meet these conditions, the PADs may decline to grant extraordinary financial relief.

(b) If the PADs grant extraordinary financial relief under this section, the Division shall recover all revenues that exceed approved program costs by applying any excess revenue against the rate the Division set for the program's next contract period unless, and only to the extent that, the Division determines that recovering excess revenues would create further financial difficulties.

(c) Providers shall apply for extraordinary financial relief in writing and file their applications with the Division, supported by any documentation the Division requires to substantiate it. It is the provider's burden to prove that the provider is experiencing demonstrable and temporary financial difficulties. If the materials filed by the provider are inadequate to serve as a basis for a reasoned decision, the application shall be denied, unless additional proofs are submitted.

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

5.102.10 Limitations on Payments

5.102.10.1 Contract Maximum

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

5.102.10.2 Upper Payment Limits

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

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

5.102.10.3 Lower of Rate or Charges

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

5.102.11 Payment for Interstate Placements

5.102.11.1 Out-of-State Services

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

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

5.102.11.2 In-State Services for Out-of-State Authorities

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

5.102.12 Administrative Review and Appeals

5.102.12.1 Draft Findings and Decisions

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

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

5.102.12.2 Request for an Informal Conference on Draft Findings and Decisions

(a) Within 15 days of receipt of either the draft findings or decision or requested work papers, whichever is the later, a provider that is dissatisfied with the draft findings or decision issued pursuant to section 5.102.12.1(a) may file a written request for an informal conference with the Division's staff on a form prescribed by the Director.

(b) Within 10 days of the receipt of the request, the Division shall contact the provider to arrange a mutually convenient time for the informal conference, which may be held by telephone. At the conference, if necessary, a date certain shall be fixed by which the provider may file written submissions or

other additional necessary information. Within 20 days thereafter, the Division shall issue its official action.

(c) A request for an informal conference must be pursued before a request for re-consideration can be filed pursuant to section 5.102.12.3.

(d) Should no timely request for an informal conference be filed within the time period specified in section 5.102.12.2(a), the Division's draft findings and/or decision are final and no longer subject to administrative review or judicial appeal.

(e) Should a provider request an informal conference, but fail to raise an issue in the request for the informal conference, the provider may not raise that issue in the informal conference or in any subsequent proceeding arising from the same action of the Division.

5.102.12.3 Request for Reconsideration

(a) A provider that is aggrieved by an official action issued pursuant to section 5.102.12.2(b) may file a request for reconsideration.

(b) The request for reconsideration must be in writing, on a form prescribed by the Director, and filed within 30 days of the provider's receipt of the official action. Should no timely request for an informal conference be filed within the time period specified in this paragraph, the official action issued pursuant to section 5.102.12.2(b) is final and no longer subject to administrative review or judicial appeal.

(c) The request for reconsideration shall include the following:

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

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

(d) Issues not raised in the request for reconsideration shall not be raised later in this proceeding or in any subsequent proceeding arising from the same action of the Division.

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

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

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

5.102.12.4 Request for Administrative Review

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

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

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

5.102.12.5 General Provisions

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

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