

STATE OF VERMONT
AGENCY OF HUMAN SERVICES
DIVISION OF RATE SETTING



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

FINAL PROPOSED RULE

APRIL 2011 JUNE 2012

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

1.11 Representation in All Matters before the Division

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

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

1.12 Severability

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

1.13 Effective Date

(a) These rules are effective from January 29, 1992, (as amended June 18, 1993, July 1, 1994, January 4, 1995, January 1, 1996, January 1, 1997, July 1, 1998, May 1, 1999, July 1, 1999, August 1, 1999, July 1, 2001, November 1, 2002, May 1, 2004, July 1, 2004, July 1, 2005, October 29, 2007,

August 25, 2008, ~~and~~ April 1, 2011 and June XX, 2012).

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

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

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

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

2 ACCOUNTING REQUIREMENTS

2.1 Accounting Principles

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

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

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

9.4 State Nursing Facilities

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

(b) Until such time as the cost report is settled, the Division shall set an interim rate based on an estimate of the facility's costs and census for the rate year.

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

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

9.5 Quality Incentives

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

(a) These payments will be based on:

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

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

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

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

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

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

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

(e) Award Criteria

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

(1) The most recent health survey report resulted in a score of five or less, no deficiency with a scope and severity greater than "D" level, with no more than two "D"

level deficiencies in the general categories of Quality of Care, Quality of Life, or Resident Rights.

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

(3) ~~Designated~~ ~~Gold~~ ~~Star~~ Provider Participation in Advancing Excellence in America's Nursing Homes campaign.

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

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

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

10 EXTRAORDINARY FINANCIAL RELIEF

10.1 Objective

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

10.2 Nature of the Relief

(a) Based on the individual circumstances of each case, the Director may recommend any of the following on such financial, managerial, quality, operational or other conditions as she or he shall find appropriate: a rate adjustment, an advance of Medicaid

payments, other relief appropriate to the circumstances of the applicant, or no relief.

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

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

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

10.3 Criteria to be Considered by the Division

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

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

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

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

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

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

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