

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



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

FEBRUARY 2014JULY 2015

TABLE OF CONTENTS

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1 GENERAL PROVISIONS	1
1.1 Scope and Purpose	1
1.2 Authority	1
1.3 General Description of the Rate Setting System	1
1.4 Requirements for Participation in Medicaid Program	1
1.5 Prior Authorization of Placement	1
1.6 Responsibilities of Owners	1
1.7 Duties of the Owner	2
1.8 Powers and Duties of the Division of Rate Setting and the Director	2
1.9 Powers and Duties of the Department of Children and Families, Department of Mental Health, Department of Disabilities, Aging and Independent Living, Department of Health's Division of Alcohol and Drug Abuse Programs and Agency of Education and other PADs relating to Rate Setting	3
1.10 Computation of and Enlargement of Time; Filing and Service of Documents	3
1.11 Representation in All Matters before the Division of Rate Setting	4
1.12 Severability	4
1.13 Effective Date	4
2 ACCOUNTING REQUIREMENTS	5
2.1 Accounting Principles	5
2.2 Procurement Standards	5
2.3 Cost Allocations	5
2.4 Substance Over Form	6
2.5 Record Keeping and Retention of Records	6
3 FINANCIAL REPORTING	7
3.1 Master File	7
3.2 Funding Application and Financial Reporting	7
3.3 Adequacy and Timeliness of Filing	8
3.4 Review of Funding Applications by Division	8
3.5 Settlement of Funding Applications	9
4 DETERMINATION OF ALLOWABLE COSTS	9
4.1 Incorporation of Provider Reimbursement Manual	9
4.2 General Cost Principles	10 10
4.3 Preapproval by PADs	10
4.4 Non-Recurring Costs	10
4.5 Property and Related Costs	10
4.6 Interest Expense	11
4.7 Basis of Property, Plant and Equipment	11
4.8 Depreciation and Amortization of Property, Plant and Equipment	12
4.9 Funding of Depreciation	12
4.10 Leasing Arrangements for Property, Plant and Equipment	12
4.11 Legal and Litigation Costs	13
Division of Rate Setting	i

4.12	Compensation of Owners, Operators, or their Relatives	13
4.13	Management Fees and Central Office Costs	13
4.14	Advertising and Public Relations	14
4.15	Bad Debts, Charity, and Courtesy Allowances	14
4.16	Related Party	14
4.17	Applied Revenues	14
4.18	Travel/Entertainment Costs	15 14
4.19	Transportation Costs	15
4.20	Costs for New Programs and Start-Up Costs	15
4.21	Compensation Limitations	15
5	CLASSIFICATION OF COSTS AND ASSIGNMENT TO SERVICE CATEGORIES	15
5.1	General	15
5.2	[Repealed]	15
5.3	Service and Administration Categories	15
6	REIMBURSEMENT STANDARDS	16
6.1	Prospective Reimbursement System and the Per Diem Rate	16
6.2	Temporary Absences	17 16
6.3	Retroactive Adjustments to Prospective Rates	17
6.4	Interim Rates	17
6.5	Base Year	17
6.6	Occupancy Level	17
6.7	Inflation Factor	17
7	CALCULATION OF COSTS, LIMITS AND RATES FOR PNMI FACILITIES	20 18
7.1	[Repealed]	18
7.2	Approved Program Costs	20 18
7.3	[Repealed]	18
7.4	Calculation of Per Diem Rate	20 18
7.5	Calculation of Per Diem Rates for Crisis/Stabilization Programs	18
7.6	Recapture of Net PNMI Revenue in Excess of Five Percent	19
8	ADJUSTMENTS TO RATES	21 19
8.1	Procedures and Requirements for Rate Adjustments	21 19
8.2	Approval of Application	21 19
9	EXTRAORDINARY FINANCIAL RELIEF	20
10	LIMITATIONS ON PAYMENTS	23 20
10.1	Contract Maximum	23 20
10.2	Upper Payment Limits	23 20
10.3	Lower of Rate or Charges	23 21
11	PAYMENT FOR INTERSTATE PLACEMENTS	23 21
11.1	Out-of-State Services	23 21
11.2	In-state Services for Out-of-State Authorities	23 21

Private Non-Medical Institutions

12 ADMINISTRATIVE REVIEW AND APPEALS	21
12.1 Draft Findings and Decisions	21
12.2 Request for an Informal Conference on Draft Findings and Decisions	21
12.3 Request for Reconsideration	22
12.4 Request for Administrative Review	22
12.5 General Provisions	23
13 DEFINITIONS AND TERMS	23
14 TRANSITIONAL PROVISIONS	26

1 GENERAL PROVISIONS

1.1 Scope and Purpose

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

1.2 Authority

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

1.3 General Description of the Rate Setting System

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

on a funding application and financial statements submitted to the Division by the provider.

1.4 Requirements for Participation in Medicaid Program

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

1.5 Prior Authorization of Placement

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

1.6 Responsibilities of Owners

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

program from full responsibility for such compliance.

1.7 Duties of the Owner

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

(a) Comply with the provisions of [§](#)Subsections 1.4, 1.5 and 1.6 setting forth the requirements for participation in the Medicaid program.

(b) Submit master file documents, funding applications and supporting documentation in accordance with the provisions of [§](#)Subsections 3.1 and 3.2 of these rules.

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

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

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

(f) Assure that the construction of buildings and the maintenance and

operation of premises and programs comply with all applicable health and safety standards.

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

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

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

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

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

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

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

Private Non-Medical Institutions

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

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

(i) Neither the issuance of final per diem rates nor final orders of the Division which fail, in any one or more instances, to enforce the requirements of these rules shall be construed as a waiver of such requirements in the future. The obligations of the provider with respect to performance shall continue, and the Division shall not be estopped from requiring such future performance.

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

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

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

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

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

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

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

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

(b) For the purposes of any provision of these rules in which time is computed from the receipt of a notice or other document issued by the Division or other

relevant administrative officer, the addressee of the notice shall be rebuttably presumed to have received the notice or other document three days after the date on the document.

(c) When by these rules or by a notice given thereunder, an act is required or allowed to be done at or within a specified time, the relevant administrative officer, for just cause shown, may at any time in her or his discretion, with or without motion or notice, order the period enlarged.

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

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

1.11 Representation in All Matters before the Division of Rate Setting

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

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

1.12 Severability

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

1.13 Effective Date

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

2 ACCOUNTING REQUIREMENTS

2.1 Accounting Principles

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

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

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

2.2 Procurement Standards

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

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

Publication 15 §2103 is subject to a disallowance.

2.3 Cost Allocations

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

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

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

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

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

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

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

2.4 Substance Over Form

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

2.5 Record Keeping and Retention of Records

(a) Each provider must maintain complete documentation, including accurate financial, medical, and statistical records, to substantiate the data reported on the funding application and on prior year's funding applications and shall, upon request, make these records available to authorized representatives of the Vermont Agency of Human Services and the United States Department of Health and Human Services.

(b) Complete documentation means clear and compelling evidence of all of the financial transactions of the provider and affiliated entities, including but not limited to census data, ledgers, books, invoices, bank statements, canceled checks, payroll records, copies of governmental filings, time records, time cards, purchase requisitions, purchase orders, inventory records, basis of apportioning costs, matters of provider ownership and organization, resident service charge schedule and

amounts of income received by service, or any other record which is necessary to provide the Director with the highest degree of confidence in the reliability of the claim for reimbursement. For purposes of this definition, affiliated entities shall extend to realty, management and other entities for which any reimbursement is directly or indirectly claimed whether or not they fall within the definition of related parties.

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

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

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

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

3 FINANCIAL REPORTING

3.1 Master File

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

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

3.2 Funding Application and Financial Reporting

(a) Funding applications and supporting documentation for services provided by these facilities shall be reported on forms prescribed by the Director pursuant to Section 1.8.

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

(c) The original signed funding application must be submitted to the Division. The original document must bear an original signature. The funding application must also be submitted to the Division in electronic format as prescribed by the Director.

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

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

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

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

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

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

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

3.3 Adequacy and Timeliness of Filing

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

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

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

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

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

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

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

3.4 Review of Funding Applications by Division

(a) Desk Review

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

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Private Non-Medical Institutions

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

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

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

(b) On-site Audit

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

(2) The Division may also reopen and audit prior years' settled funding

applications if there is evidence and/or complaints of financial irregularities at the program.

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

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

3.5 Settlement of Funding Applications

A funding application is settled if there is no request for reconsideration of the Division's findings or, if such request was made, the Division has issued a final order pursuant to [§](#) subsection 12.3 of these rules.

4 DETERMINATION OF ALLOWABLE COSTS

4.1 Incorporation of Provider Reimbursement Manual

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

specifically covered in the sources referenced in this subsection.

4.2 General Cost Principles

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

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

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

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

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

(1) direct qualified staff salaries and benefits,.

(2) other direct program costs,

(3) direct program administrative costs and

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

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

4.3 Preapproval by PADs

Preapproval is encouraged for providers anticipating a significant increase in

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

4.4 Non-Recurring Costs

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

4.5 Property and Related Costs

Property and related costs include:

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

(b) interest on capital indebtedness,

(c) real estate leases and rents,

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

Private Non-Medical Institutions

- (e) equipment rental,
- (f) fire and casualty insurance,
- (g) amortization of mortgage acquisition costs and non-recurring costs, and
- (h) repairs and maintenance.

4.6 Interest Expense

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

(b) “Necessary” requires that:

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

(2) Interest expense shall be reduced by realized investment income, with the exception of investment income on funded depreciation, pursuant to [S](#)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 [S](#)subsection 4.3, if the necessary approval has not been granted.

4.7 Basis of Property, Plant and Equipment

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

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

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

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

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

4.8 Depreciation and Amortization of Property, Plant and Equipment

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

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

(c) The estimated useful life of an asset shall be determined as follows:

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

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

4.9 Funding of Depreciation

Funding of depreciation is not required but it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciable assets, and coordinate their planning of capital expenditures with area-wide planning of community and state agencies.

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

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

4.10 Leasing Arrangements for Property, Plant and Equipment

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

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

Private Non-Medical Institutions

for facilities purchased elsewhere, whichever is lower.

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

4.11 Legal and Litigation Costs

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

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

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

4.12 Compensation of Owners, Operators, or their Relatives

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

circumstances such as those listed in paragraph (b) of this subsection.

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

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

(2) The unduplicated functions actually performed.

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

4.13 Management Fees and Central Office Costs

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

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

subsection 4.21 to impute a reasonable amount of compensation that may be allowed for PNMI reimbursement for the individual owner or employee. No consulting costs or any other form of compensation shall be allowed in addition to the imputed allowable salary amount.

4.14 Advertising and Public Relations

The following costs are not allowable:

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

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

4.15 Bad Debts, Charity, and Courtesy Allowances

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

4.16 Related Party

Expenses otherwise allowable shall not be included for purposes of determining a prospective rate where such expenses are paid to a related party unless the provider identifies any such related party and the expenses attributable to it and demonstrates that such expenses are the actual cost to the related party without any markup or any additional negotiated fees. The Division may require either the provider or the related party, or both, to submit information, books and records relating to such expenses for the purpose of determining their allowability, including

the related party audited financial statements.

4.17 Applied Revenues

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

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

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

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

4.18 Travel/Entertainment Costs

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

4.19 Transportation Costs

Costs of transportation incurred, other than ambulance services covered pursuant to the *Vermont Medicaid Covered Services Rules*, that are necessary and reasonable for the care of residents are allowable. Such costs shall include depreciation of vehicles, mileage reimbursement to employees for the use of their vehicles to provide transportation for residents, and any contractual arrangements for providing such transportation. Such costs shall not be separately billed for individual residents. Providers shall keep vehicle mileage logs and other similar records to track program costs for transportation.

4.20 Costs for New Programs and Start-Up Costs

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

(b) The PADs may authorize reimbursement for pre-opening start-up cost for new programs. Application for approval of such reimbursement should be made before the expense is incurred.

Eligible costs may include, but are not limited to capital expenditures, supplies, staffing and training costs. Reimbursement may be made by lump-sum payments or by the addition of the start-up costs to the program's approved budget for its first year of operation.

4.21 Compensation Limitations

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

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

5 CLASSIFICATION OF COSTS AND ASSIGNMENT TO SERVICE CATEGORIES

5.1 General

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

5.2 [Repealed]

5.3 Service and Administration Categories

There are three service categories that are directly related to the provision of services to the residents and a fourth category which relates to the administration of the

program. All allowable program costs shall be allocated to these four categories. To determine total allowable program costs, the administration category is re-allocated to the three service categories.

(a) Service Categories

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

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

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

(b) Program Administration: In addition to the service categories above, administrative expenses related to the operation of the program are recognized

allowable costs. Program administration costs include direct program administrative costs and indirect administrative allocations.

6 REIMBURSEMENT STANDARDS

6.1 Prospective Reimbursement System and the Per Diem Rate

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

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

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

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

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

Private Non-Medical Institutions

the Division which will issue a determination after consultation with the PADS.

6.2 Temporary Absences

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

6.3 Retroactive Adjustments to Prospective Rates

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

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

(1) as an adjustment pursuant to Section 9;

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

(3) for mechanical computation or typographical errors;

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

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

(6) recovery of overpayments pursuant to subsection 10.1 as a result of a

provider exceeding the contract maximum; or

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

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6.4 Interim Rates

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

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

6.5 Base Year

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

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

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

6.6 Occupancy Level

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

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

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

6.7 Inflation Factor Cap on Increases from Prior Base Year to Current Base Year

~~The Division shall limit programs' per diem rates by an inflation factor calculated pursuant to this subsection. The inflation factor shall reflect the allowable weighted inflation percentage that will be applied to programs' prior rate year's final per diem rates as a maximum allowed per diem rate in the current rate year.~~

~~(a) The Division shall use the most recent version of the Health Care Cost Service available as of June 1 in the calculation of the inflation factor and shall calculate inflation from the previous base year calendar year to the current base year calendar year. In the calculation of the inflation factor, the Division shall weight the following price indexes as follows:~~

~~(1) Salaries and wages—The Division shall multiply the Wages and Salaries portion of the CMS Home Health Agency Market Basket times a weighted factor of 50 percent.~~

~~(2) Fringe benefits—The Division shall multiply the Employee Benefits portion of the CMS Home Health Agency Market Basket times a weighted factor of 15 percent.~~

~~(3) Other—The Division shall multiply the All Other index of the CMS Home Health Agency Market Basket times a weighted factor of 35 percent.~~

~~(b) To determine the inflation factor, the Division shall add the weighted price indexes in paragraph (a) of this subsection. The Division shall cap the programs' increases by calculating a maximum increase from the prior base year to the current base year pursuant to this subsection.~~

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

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

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

~~(i) If the current base year resident days are equal to or greater than the prior base year resident days, the~~

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Private Non-Medical Institutions

division shall multiply the prior year per diem rate as calculated pursuant to paragraph (a)(1), excluding rate adjustments, by 100%. The result will be the occupancy adjusted per diem rate.

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

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

days from the prior base year. The result will be the occupancy adjusted per diem rate.

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

The table below shows the factor to be applied to the occupancy adjusted prior base year per diem rate to calculate the cap on the current year per diem rate in accordance with paragraph (a)(4). This factor is on a scale that relates to the magnitude of the programs’ prior base year allowable costs before revenue offset.

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

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

(b) For crisis/stabilization programs with rates calculated pursuant to subsection 7.5, the Division shall cap

cost increases from year to year as follows:

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

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

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

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

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

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

7 CALCULATION OF COSTS, LIMITS AND RATES FOR PNMI FACILITIES

7.1 [Repealed]

7.2 Approved Program Costs

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

7.3 [Repealed]

7.4 Calculation of Per Diem Rate

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

(b) The Division shall limit the current rate period's per diem rate by the ~~final per diem rate in the prior rate period, without any recapture of net PNMI revenue in excess of five percent, inflated by the inflation factor percentage cap~~ calculated pursuant to subsection 6.7.

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

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

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7.5 Calculation of Per Diem Rates for Crisis/Stabilization Programs

For programs categorized by the PADs as crisis/stabilization programs with typical lengths of stay from 0 – 10 days, 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 ~~inflation factor percentage cap~~ calculated pursuant to subsection 6.7(b).

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

7.6 Recapture of Net PNMI Revenue in Excess of Five Percent

The Division will review programs’ audited financial statements and will recapture PNMI profit by applying the net revenue in excess of five percent against the current year’s total allowable costs. The calculation of the recapture of net PNMI revenue in excess of five percent shall ~~be applied after the inflation cap limitation.~~ take into consideration the effect of the cap in subsection 6.7. Any

amounts of revenue offset which are greater than the effect of the cap will be offset.

8 ADJUSTMENTS TO RATES

8.1 Procedures and Requirements for Rate Adjustments

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

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

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

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

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8.2 Approval of Application

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

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

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

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

(e) Approved rate adjustments will not be subject to the ~~inflation~~ cap limitation pursuant to subsections ~~6.7, 7.4(b) and 7.5(e)~~.

8.3 Limitations on Availability of Rate Adjustments

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

9 EXTRAORDINARY FINANCIAL RELIEF

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

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

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

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Private Non-Medical Institutions

(c) Procedure - An application for extraordinary financial relief shall be in writing and filed with the Division. It shall be supported by such documentation as the Division may require. The burden of proof is at all times on the provider. If the materials filed by the provider are inadequate to serve as a basis for a reasoned decision, the application shall be denied, unless additional proofs are submitted.

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

10 LIMITATIONS ON PAYMENTS

10.1 Contract Maximum

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

10.2 Upper Payment Limits

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

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

10.3 Lower of Rate or Charges

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

11 PAYMENT FOR INTERSTATE PLACEMENTS

11.1 Out-of-State Services

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

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

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

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

12 ADMINISTRATIVE REVIEW AND APPEALS

12.1 Draft Findings and Decisions

(a) Before issuing findings on any desk review or audit of a funding application, ~~decision on any application request~~ for a rate adjustment, ~~extraordinary financial~~

~~relief~~—or other request excluding extraordinary financial relief, the Division shall serve a draft of such findings or decision on the affected provider.

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

12.2 Request for an Informal Conference on Draft Findings and Decisions

(a) Within 15 days of receipt of either the draft findings or decision or requested work papers, whichever is the later, a provider that is dissatisfied with the draft findings or decision issued pursuant to Ssubsection 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 Ssubsection 12.3.

(d) Should no timely request for an informal conference be filed within the time period specified in Ssubsection 12.2(a), the Division's draft findings and/or deci-

sion are final and no longer subject to administrative review or judicial appeal.

12.3 Request for Reconsideration

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

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

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

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

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

Private Non-Medical Institutions

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

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

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

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

12.4 Request for Administrative Review

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

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

materials that represent the documentary record of the Division's action.

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

12.5 General Provisions

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

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

13 DEFINITIONS AND TERMS

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

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

AICPA: American Institute of Certified Public Accountants.

Allocable cost: A cost which is incurred for a service that is designed to achieve two or

more objectives, not all of which are covered by the Medicaid program.

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

AOE: the Vermont Agency of Education.

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

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

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

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

Centers for Medicare and Medicaid Services (CMS): Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.

Common Control: where an individual or organization has the power to influence or direct the actions or policies of both a provider and an organization or institution serving the provider, or to influence or direct the transactions between a provider and an organization serving the provider. The term

includes direct or indirect control, whether or not it is legally enforceable.

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

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

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

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

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

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

DMH: Department of Mental Health.

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

Facility: a residential treatment program, licensed as such by the Department for Children and Families' Residential Licensing and Special Investigations Unit, and enrolled

Private Non-Medical Institutions

in the Vermont Medicaid Program as a Private Nonmedical Institution for Child Care Services.

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

FASB: Financial Accounting Standards Board.

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

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

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

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

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

FASB Concepts Statements, (8) AICPA Issues Papers and Practice Bulletins, and other pronouncements of the AICPA or FASB.

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

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

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

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

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

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

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

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

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

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

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

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

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

~~**Provider Contract:** a provider contract is a standard form contract 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: a manual published by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, used by the Medicare Program to determine allowable costs.

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

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

Private Non-Medical Institutions

lender, with respect to the provider, or is related by family to such persons.

Resident: an individual who is receiving services in a Private Nonmedical Institution for Residential Child Care Facility.

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

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

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

Secretary: the Secretary of the Agency of Human Services.

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

§ 14 TRANSITIONAL PROVISIONS

(a) The Division shall add \$500 to the state fiscal year 2014 total rate year allowable costs for each program so that programs may begin to request that their the independent public accountants prepare the PNMI sub-schedule as part of each program's next annual audit pursuant to subsection 1.7(d) and 3.2(d). If the costs for these sub-

schedules are not in the programs' state fiscal rate year 2015 costs, the Division will also add \$500 to the base total allowable costs so that programs may have this PNMI sub-schedule prepared as part of the annual audit.

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

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

(d) The first year that the Division shall apply the ~~inflation cap limitation cap~~ pursuant to subsections ~~6.7, 7.4(b) and 7.5(e)~~ is the rate year that uses base year 2014 costs.