

**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**

Adopted Rule

August 2008



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Cite as Vermont Private Nonmedical Institutions Rules (V.P.N.M.I.R.)

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## **1 GENERAL PROVISIONS**

### **1.1 Scope and Purpose**

These rules apply to all private nonmedical institutions participating in the Vermont Medicaid program and providing services in licensed residential child care facilities. 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 contract based on budgeted costs for the contract year. 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 program budget 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 facility must be licensed by the Department of Social and Rehabilitation Services as a residential child care facility, have an approved Medicaid provider agreement with Department of Social Welfare, and have an approved contract with at least one of the placement authorizing departments (PAD) as defined in Section 12 of these rules.

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

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

### **1.6 Responsibilities of Owners**

The owner of a residential child care facility shall prudently manage and operate a residential health care 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 Department of Education, including the Department of Social and Rehabilitation Services' *Licensing Regulations for Residential Child Care Services*. 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 facility from full responsibility for such compliance.

## **1.7 Duties of the Owner**

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

(a) Comply with the provisions of Subsection 1.4 setting forth the requirements for participation in the Medicaid program.

(b) Submit master file documents and funding applications in accordance with the provisions of Subsections 3.1, 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 in conformance with Generally Accepted Auditing Standards (GAAS).

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

## **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 child care facility or related party or organization to file such relevant and appropriate data, statistics, schedules or information as the Division finds necessary to enable it to carry out its rate setting function.

(c) The Division may examine books and accounts of any facility 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 child care facility participating in the Medicaid program at the time it is issued. A compilation of all such documents currently in force shall be maintained at the Division, pursuant to 3 V.S.A. §835, and shall be available to the public.

(g) Neither the issuance of final per diem rates nor final orders of the Division which fail, in any one or more instances, to enforce the 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.

(h) 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).

**1.9 Powers and Duties of the Department of Social and Rehabilitative Services, Department of Mental Health/Mental Retardation and Department of Education and other PADs relating to Rate Setting**

- (a) SRS shall prescribe procedures and forms to be used in the completion of time studies.
- (b) PADs retain the right to review, modify, accept or reject PNMI program budgets and per diem rates before they are issued as final.
- (c) SRS, in consultation with the appropriate PADs, shall establish and certify to the Division the occupancy standards to be used in the rate setting process.
- (d) PADs shall approve all FTEs and staffing patterns to be used in the budgeting process. These standards shall be referenced in all contracts for residential child care services.
- (e) The PADs shall establish and enforce billing and payment procedures.
- (f) The PADs reserve the right to review, modify, accept or reject any adjustment requests made in accordance with Section 8 of these rules.

(g) SRS is responsible for licensing standards and enforcement. SRS, in conjunction with the other PADs is 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 by electronic data transfer at such time as appropriate software and filing procedures are developed and approved by the Division.

(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 and August 5, 2008).

## **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 its employees engaged in purchasing goods and services. Such standards shall provide, to the maximum extent practical, open and free competition among vendors. Providers should participate in group purchasing plans when feasible.

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

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

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

(a) New facilities or those that are new to the Medicaid program shall submit to the Division a proposed cost allocation in conjunction with the initial funding application.

(b) Providers that have costs allocated from related entities included in their funding applications shall include, as a part of their funding applications submission, a summary of the allocated costs, including a reconciliation of the allocated costs to the entity's financial statements which must also be submitted with the funding application. In the case of a

central office or related management company, this would include a completed central office proposed budget and financial statements. The provider shall submit this reconciliation with the funding application.

(c) No change in accounting principles or methods or basis of cost allocation may be made without prior written approval of the Division.

(d) Any application for a change in accounting principle or a change in the method or basis of cost allocation, which has an effect on the amount of allowable costs or the computation of the per diem rate of payment, shall be made within 180 days prior to the start of the contract year. The application shall specify:

(1) the nature of the change;

(2) the reason for the change;

(3) the likely effect of the change on future per diem rates of payment; and

(e) The Division shall review each application and within 60 days of the receipt of the application approve, deny, or propose modifications of the requested change. If no action is taken within the specified period, the application shall be deemed to have been approved.

(f) 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.

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

(1) Salaries/wages - Time studies identifying and dividing time between that spent working for the PNMI, time working in other programs operated by the central office, and the division of time among the major service categories of the PNMI program. The time study must be completed on a form and in a manner approved by SRS.

(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, to the major service categories. 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; within the PNMI program, 100 percent of the costs allocated to the room, board and supervision service category.

(5) Administrative and General - Allocated in the same proportion as the total direct and allocated direct costs.

(6) Transportation - Allocated by the number of trips or the actual mileage used for each service category. If no trip or mileage logs are kept sufficient to identify the purpose of the trip and mileage used, all allowable costs will be allocated to the Room, Board and Supervision Service Category.

(7) Property & Related - Depreciation of equipment - specific identification.

(h) All administrative and general costs, including central office and management company costs allocated to the program shall be classified as "Indirect" and allocated to the service categories, based on the percentage of total program costs by service category.

(i) 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

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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)(6), 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) Copies of the articles of incorporation and bylaws,

(b) chart of accounts and procurement standards established pursuant to subsection 2.2(a),

(c) plant layout,

(d) terms of capital stock and bond issues, if applicable,

(e) copies of long-term contracts, including but not limited to leases, pension plans, profit sharing and bonus agreements,

(f) schedules for amortization of long-term debt and depreciation of plant assets,

(g) summary of accounting principles, cost allocation plans, and statistics used by the provider,

(h) current list of the board of directors,

(i) personnel policies, and

(j) 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 Division may require providers to file funding applications for periods other than a facility's fiscal year.

(c) The funding application must include the certification page signed by the owner, or its representative, if authorized in writing by the owner.

(d) The original and three copies of the funding application must be submitted to the Division. All documents must bear original signatures.

(e) A provider must submit audited financial statements with the funding application.

(f) 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) summary results of the most recently completed time study,

(2) budget narratives; brief descriptions of each line item,

(3) financial assumptions and calculations used to determine budgeted amounts,

(4) disclosure of significant changes, programmatic or financial, from the prior contract period,

(5) year-to-date trial balance of all statements of revenue and expenses, including budget versus actual,

(6) any contracts currently in force that affect programs under review,

(7) disclosure of transactions with related parties,

(8) statistics or any explanation of any indirect cost allocations,

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

(10) summary census records,

(11) payroll records,

(12) reconciliation of audited financial statements to costs submitted on the funding application for the prior year, and

(13) certificates of insurance for property, vehicle and liability coverage.

(g) The provider must also submit, upon request during the desk review or audit process, such data, statistics, schedules, or other information which the Division requires to carry out its function.

### **3.3 Adequacy and Timeliness of Filing**

(a) The funding application must be filed with the Division on a schedule to be prescribed by the Director for each provider.

(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 beyond the prescribed deadline must be requested as follows:

(1) All Requests for Extension of Time to File a Funding Application must be in writing, on a form prescribed by the Director, and must be received by the Division of Rate Setting at least 15 days 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 report.

(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 a

funding application preparer engaged in other work.

(d) When rate setting is delayed because the funding application is incomplete or untimely, or requested information is not provided in a timely manner, the rate for the previous contract period 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 contract period.

### **3.4 Review of Funding Applications by Division**

(a) Desk Review

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

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

(3) Desk reviews shall be completed within 90 days 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 audit scope will be limited so as to avoid duplication of work performed by a provider's independent public accountant, provided such work is adequate to meet the Division's audit requirements.

(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 11.

### **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 11.3 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 (HCFA-15, formerly known as HIM-15), which is hereby incorporated by reference. If neither these regulations nor HCFA-15 specifically addresses a particular issue, the determination of allowability will be made in accordance with Generally Accepted Accounting Principles. 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.

(1) Direct qualified staff salaries and benefits as determined by the PADs and the Division.

(2) Other direct program costs as outlined in these regulations.

(3) Direct program administrative costs as outlined in these regulations.

(4) Indirect allocated administrative (central office) costs as outlined in these regulations.

(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**

Providers must obtain pre-approval from the PADs before making commitments to any expenditures which would result in a material increase (as defined by the Division in consultation with the PADS) in the current approved program budget 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.

#### **4.4 Non-Recurring Costs**

Any reasonable and resident-related, non-capital cost that would increase the approved budget 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**

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

(b) interest on capital indebtedness,

(c) real estate leases and rents,

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

(e) equipment rental,

(f) fire and casualty insurance,

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

(h) repairs and maintenance.

#### **4.6 Interest Expense**

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

(b) “Necessary” requires that:

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

(2) Interest expense shall be reduced by realized investment income, with the exception of investment income on

funded depreciation, pursuant to Subsection 4.9.

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

(d) "Proper" requires that:

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

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

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

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

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

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

loan's unpaid interest charges, to the extent that it is included in the refinanced loan's principal, shall not be allowed.

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

#### **4.7 Basis of Property, Plant and Equipment**

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

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

(1) purchase price,

(2) sales tax, and

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

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

(d) Any asset that has a basis of \$750 or more and an estimated useful life of two or more years must be capitalized and depreciated in accordance with Subsection 4.8.

#### **4.8 Depreciation and Amortization of Property, Plant and Equipment**

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

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

(c) The depreciation basis established according to Subsection 4.7, net of any salvage value.

(d) 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 HCFA-15.

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

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

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

(a) Rental expense on facilities and equipment leased from a related organization will be limited to the Medicaid allowable interest, depreciation, insurance and taxes for the year under review, or the price of comparable services for facilities purchased elsewhere, whichever is lower. In the case of a for-profit provider, where the related party has no debt on the leased property, the Division may use return on equity as a proxy for interest expense. The rate of return shall equal the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the period covered by the financial statements filed with the provider's funding application.

(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 HCFA-15.

(2) The unduplicated functions actually performed, as described by the provider on the funding application.

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

(4) The number of years of pertinent experience and any additional supporting statements relative to the attainment of special expertise needed by the facility which further substantiate the need for exceptional consideration.

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

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

#### **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 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 do not exceed the lower of the cost to the related party or the price of comparable services, facilities or supplies that could be purchased elsewhere. The Division may 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.

**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. The application of these revenues shall be calculated according to subsection 7.2.

(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 budgeted and allowable, interest or investment income earned by the PNMI programs or central office will be applied against the program or

central office budget when calculating the net 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 budget for that program or central office projects costs are payable from that revenue source. If the donor restricted contribution does not cover expenses budgeted in the PNMI program or central office, then the revenue will not be applied.

(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. However, the provider may designate some or all of its unrestricted contributions to be used in the PNMI program, in which case the amount of the funds so designated shall be applied when calculating the net allowable program costs.

(d) 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. The treatment of these revenues will depend on whether or not the money was raised for a restricted purpose.

(e) Recovery of Revenues in Excess of Program Budget - In the event that a program or provider's actual net allowable costs are lower than the program budget or the occupancy rate was higher than projected for rate setting purposes in the last

contract year for which audited financial statements are available, revenues earned in excess of five percent of the program budget will be applied against the next year's program budget.

#### **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 Policy Manual*, that are necessary and reasonable for the care of residents are allowable. Such costs shall include depreciation of utility vehicles, mileage reimbursement to employees for the use of their vehicles to provide transportation for residents, and any contractual arrangements for providing such transportation. Such costs shall not be separately billed for individual residents.

#### **4.20 Start-Up Costs**

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.

(a) Eligible costs may include, but are not limited to capital expenditures, supplies, staffing and training costs. Such costs shall be assigned to the appropriate service cost categories, pursuant to V.P.N.M.I. R. §5.3(a).

(b) Reimbursement may be made by lump-sum payments or by the addition of the start-up costs to the program's approved budget for its first year of operation.

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

#### **5.1 General**

In the PNMI system of reimbursement, allowable budgeted costs are first classified and then assigned to a service category.

(a) The cost classification is determined by the type of expense and whether or not the expense can be directly charged to the program and within the program to one of the service categories.

(b) The service categories are determined by the type of services purchased with the expenditure and the source of funding for those expenditures.

#### **5.2 Cost Classifications**

The accounts to be used for each cost classification shall be prescribed by the Director. Allowable costs shall be grouped into the following classes:

(a) Direct Program Costs - are allowable costs associated with expenses directly related to the provision of services to the resident. The following are examples of direct program costs:

## Private Non-Medical Institutions

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(1) salaries/wages and benefits of qualified staff actively participating in the categories of service,

(2) Non-salaried personnel actively participating in the categories of service or supporting the plan of care,

(3) Food, household supplies, educational supplies, client incidentals directly related to resident care,

(4) Transportation related to the three categories of service,

(5) Property and related costs which can be directly allocated to the categories of service, and

(6) Any other budgeted line item that can be directly allocated to one of the service categories.

(b) Direct Program Administrative Costs - are allowable costs which relate to the administration of the overall program but are not directly related to the provision of services to the resident. Direct program administrative costs must be solely related to the program. The following are examples of these costs:

(1) salaries/wages and benefits of administrative duties of supervisors and program directors solely dedicated to the program,

(2) salaries/wages and benefits of any administrative personnel such as bookkeepers and clerical help solely dedicated to the program,

(3) office supplies, postage, phone costs not allocable to the service categories, but solely dedicated to the program,

(4) transportation not directly related to the three categories of service, but solely related to the program,

(5) property and related costs which cannot be directly identified to the service categories, but are solely related to the program, and

(6) any other cost that is solely related to the program but cannot be directly allocated to the service categories.

(c) Indirect Administrative Allocation - are allowable costs which are not solely incurred for the program or provision of services to the program's residents, but are necessary to the operation of the program. Indirect administrative allocation costs relate to a central office or management company that operates two or more programs. All indirect administrative allocation costs are subject to the reasonable, necessary, allowable and accounting standards set forth in these rules.

### 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 on the funding application. 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 facilities 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 a recognized allowable cost.

(1) Direct Program Administrative Costs: These costs are described in subsection 5.2(b) and shall be reported on the funding application along with all other direct program costs.

(2) Indirect Administrative Allocation: These costs are described in subsection 5.2(c) and shall be reported separately from the direct program costs on the funding application.

## **6 PAYMENT FOR SERVICES**

### **6.1 Per Diem Rate**

(a) 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.

(b) 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 9. Billing and payment procedures shall be determined by the PADs.

(c) 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 budget. If a provider is unsure whether a type of service has been included in the approved program budget, it must refer the question to the Division which will issue a determination after consultation with the PADS.

### **6.2 Temporary Absences**

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

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

### **7.1 Total Allowable Costs**

(a) The type and cost of services and levels of expenditures included in the funding application are subject to review by the Division in conjunction with the PADs. The amount of costs that will be recognized for rate setting purposes may be modified based on the particular services, staffing, and program design needed by the PADs.

(b) The Division, in consultation with the PADs, may issue guidelines to assist facilities in developing their budgets for the contract period.

(c) The total allowable costs for the contract period, based on prior year actual allowable costs, current year costs and funding levels, and preapproved changes expected in the contract period, as reported by the facility, are used to determine the level of reasonable costs to be recognized in setting the rate for the contract period. Only costs that are allowable pursuant to Section 4, 4 are included in calculating the total allowable costs.

## **7.2 Approved Program Budget**

The calculation of the rates shall be based on an approved budget determined by the Division, in consultation with the PADs. The approved budget is determined as follows:

(a) Total Allowable costs are determined pursuant to Subsection 7.1(c).

(b) Applied Revenues - From the total allowable costs, applied revenues, as calculated pursuant to subsection 4.17, are deducted to produce net allowable costs.

(c) Approved program budget - The net allowable costs equal the approved program budget for the contract period.

## **7.3 Occupancy Level**

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

(b) Exceptions to the occupancy guidelines may be granted to programs receiving financial relief, pursuant to V.P.N.M.I.R. §8.3.

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

(a) The approved program budget is divided by the estimated occupancy level to determine the per diem rate.

(b) A per diem rate, subject to the approval of the PADs, will be developed for each of the service categories as set out in subsection 5.3(a).

## **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) Only one application per provider will be allowed during a contract year, and must be filed no sooner than the beginning of the fourth month of the contract. 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 materiality test for a rate adjustment is not met if the change in the per diem rate after the adjustment would be smaller than three percent of the overall per diem rate in effect at the time.

## 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 was set.

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

(c) 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.

(d) For adjustments requiring prior approval of the Division, such approval should be sought before the provider makes any commitment to expenditures.

## 8.3 Financial Relief

A rate adjustment 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 a rate adjustment 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 the rate adjustment an earlier point in the contract period, for an increase in approved program budget, 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 budget. To the extent that revenues exceed the approved program budget for the contract period, the Division shall apply such excess against the program's budget for the current period pursuant to V.P.N.M.I.R. §4.17(e), except that no allowance shall be made for excess

revenues of up to five percent, and all excess revenues shall be applied unless the Division determines that such application of excess revenues would create further financial difficulties.

(c) Procedure - An application for 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 Application by 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 facility or for any other facility.

## **9 LIMITATIONS ON PAYMENTS**

### **9.1 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.

### **9.2 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.

### **9.3 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.

## **10 PAYMENT FOR INTERSTATE PLACEMENTS**

### **10.1 Out-of-State Services**

(a) Reimbursement shall not be made for PNMI residential child care services provided out of state unless the services are not available within the state. No reimbursement shall be available unless prior authorization has been granted by the Medicaid Division.

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

### **10.2 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 child care facilities 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.

## **11 ADMINISTRATIVE REVIEW AND APPEALS**

### **11.1 Draft Findings and Decisions**

(a) Before issuing findings on any Desk Review or Audit of a Funding Application or decision on any Application for a Rate Adjustment, 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.

### **11.2 Request for an Informal Conference on Draft Findings and Decisions**

(a) Within 15 days of receipt of either the draft findings or decision or requested work papers, whichever is the later, a provider that is dissatisfied with the draft findings or decision issued pursuant to Subsection 11.1(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, SRS, in conjunction with the PADs, shall issue its official action.

(c) A Request for an Informal Conference must be pursued before a Request for Reconsideration can be filed pursuant to Subsection 11.3.

(d) Should no timely Request for an Informal Conference be filed within the time period specified in Subsection 11.2(a), the Division's draft findings and/or decision are final and no longer subject to administrative review or judicial appeal.

### **11.3 Request for Reconsideration**

(a) A provider that is aggrieved by an official action issued pursuant to Subsection 11.2(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.

(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, HCFA-15, or other authority for the requested relief and the rationale for the requested remedy; and
- (3) if no hearing is requested, evidence necessary to bear the provider's burden of proof, including, if applicable, a proposed revision of the Division's calculations, with supporting work papers.

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

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

(f) The hearing shall be conducted by the Director or her or his designee. The testimony shall be under oath and shall be recorded either stenographically or on tape. If the provider so requests, the Division staff involved in the official action appealed shall appear and testify. Representative 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 Request for Reconsideration no later than 30 days after the record closes.

#### **11.4 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.

#### **11.5 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.

### **12 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 facilities to its residents.

**Approved Program Budget:** the net allowable costs for the contract period after the deduction of applied revenues.

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

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

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

**DMH/MR:** Department of Mental Health/Mental Retardation.

**DOE:** the Vermont Department of Education.

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

**Facility:** a Residential Child Care Facility, licensed as such by the SRS Division of Licensing and Regulation, and enrolled in the Vermont Medicaid Program as a Private Nonmedical Institution for Child Care Services.

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

**FASB:** Financial Accounting Standards Board.

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

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

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

**Funding Application:** A 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 Financing Administration (HCFA):** Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.

**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.

**Occupancy Level:** the number of paid days, including temporary absence days, as a

percentage of the total permitted number of total permitted resident capacity.

**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 child care facility. PADs include but are not limited to the Department of Social and Rehabilitation Services, the Department of Mental Health/Mental Retardation, or the Department 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 of Social and Rehabilitation Services as a Residential Child Care Facility and have a Medicaid Provider Agreement in effect with the Department of Social Welfare.

**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 Social Welfare, Medicaid Division 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.

**Provider Reimbursement Manual, HCFA-15:** a manual published by the U.S. Department of Health and Human Services, Health Care Financing Administration, used by the Medicare Program to determine allowable costs.

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

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

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

**Residential Child Care Facility:** a private or public agency or facility that is licensed by the Department of Social and Rehabilitation Services (SRS) under the “Licensing Regulations for Residential Child Care Facilities.”

**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.

**SRS:** The Vermont Department of Social and Rehabilitation Services.

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

## § 13 TRANSITIONAL PROVISIONS

Notwithstanding any other provisions of these rules, for the period July 1, 2008 through June 30, 2009 (state fiscal year 2009), the PNMI per diem rates shall be calculated pursuant to this section.

(a) General Rule. PNMI per diem rates for state fiscal year 2009 shall be 103.75 percent of each program’s final per diem rate in effect on June 30, 2008, with the following exceptions:

(1) For providers whose rates as of June 30, 2008 are not yet final, an interim rate will be set on July 1, 2008, based on the Division’s most recently published budget and occupancy findings for the prior rate period, inflated by 3.75 percent. At such time as the rate for the prior period, which includes June 30, 2008, is final, a final rate for state fiscal year 2009 shall be set, which shall equal 103.75 percent of the final rate in effect on June 30, 2008.

The notice of an interim rate is not a final order of the Division and is not subject to review or appeal pursuant to Section 11 of these rules. Any overpayments or underpayments resulting from the difference between the interim and final rates will be either refunded by the provider or paid to the provider.

(2) Those programs whose per diem rates as of June 30, 2008 include an approved rate adjustment pursuant to Section 8 of these rules shall receive no rate change until the expiration of the rate period to which the adjustment applies. At the expiration of that rate

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period, a new rate shall be set for the remainder of state fiscal year 2009, which shall equal 103.75 percent of the rate before the Section 8 adjustment became effective.

(3) For programs categorized by the PADS as Crisis/Stabilization programs with typical lengths of stay from 0 – 10 days, rates for state fiscal year 2009 will be set retroactively as follows:

(i) The allowable budget will be 103.75 percent of the final approved budget for the rate year which includes June 30, 2008. The monthly allowable budget will be the allowable budget divided by 12.

(ii) Within 10 days of the end of each month in state fiscal year 2009, the program will submit the prior month's census to the Division. The per diem rate will be set for the prior month by dividing the monthly allowable budget amount by the total number of resident days for the month just ended.

(b) Except as otherwise provided for in this section, all rates set for state fiscal year 2009 shall be issued as final.

(c) Providers are not required to submit funding applications or financial reporting pursuant to Section 3 of these rules for state fiscal year 2009.

(d) Pursuant to Section 8, adjustments to state fiscal year 2009 final rates may be available. The provisions of Section 8 are modified as follows for state fiscal year 2009:

(1) The four-month waiting provision of subsection 8.1(b) is waived.

(2) For rate adjustments relating to program changes, providers may submit Section 8 applications up to 60 days in advance of the anticipated program changes.

(3) Except as otherwise provided for in this section, all providers must receive prior written approval from the appropriate PAD before applying to the Division for any Section 8 adjustment. The written approval must be submitted to the Division with the Section 8 application.

(4) Section 8 adjustments shall be expanded, for state fiscal year 2009 only, to include applications for adjustments to property costs for increases in the total amount of interest, lease expense and depreciation/amortization that are at a minimum 10 percent or greater than the final approved budget amount for the rate year that includes June 30, 2008. No prior approval from the PADs is required for this type of Section 8 adjustment.