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Health Care Administrative Rules Introduction

1.100 Health Care Administrative Rules Introduction (12/16/2016, GCR 16-076)

(a) The Agency of Human Services is the "single State agency," pursuant to 42 U.S.C. 1396a (a)(5), responsible for the operation of the Medicaid program in Vermont.

(b) The Agency of Human Services administers Vermont's Medicaid program with the support and assistance of the Departments that comprise the Agency. The Agency of Human Services includes the Department of Vermont Health Access, Department of Mental Health, Department of Disabilities, Aging, and Independent Living, Department for Children and Families, Department of Corrections, and Vermont Department of Health. The Agency assigns the Departments the responsibility for ensuring that persons eligible for Medicaid services are properly enrolled, covered services are provided, health care providers are paid, and the rights of beneficiaries in the program are respected.

(c) These Health Care Administrative Rules coordinate and consolidate the State of Vermont rules that pertain to the operation of Vermont's Medicaid program. Consolidated and well-organized rules written in plain language permit Medicaid beneficiaries and providers convenient access to the regulations, increases comprehension of sometimes technical concepts and program requirements, and ensures consistent policy administration of the program throughout the Agency of Human Services.

(d) The Health Care Administrative Rules are applicable to the entirety of Vermont's Medicaid program, without regard to whether the programs are operated and managed by any individual Department within the Agency of Human Services. As such, with two limited exceptions, the Health Care Administrative Rules take precedence over any rules, policies, and guidelines maintained by individual Departments in connection with their operation of the portions of the Medicaid program for which they are responsible, if any inconsistencies between them exist. The first exception concerns certain specialized services contained in programs and services authorized by federal "waivers" of Medicaid program requirements. Those programs and services are reflected at Chapter 7 of these rules, entitled Specialized Services and Programs. The rules, policies, and guidelines relating to such Specialized Services and Programs take precedence over the more general coverage, limitation, prior authorization, and eligibility rules contained throughout these Health Care Administrative Rules. The second exception relates to the provision of Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) required under the Medicaid Act. Vermont Medicaid pays for all medically necessary services for beneficiaries under the age of 21 without regard to service limitations otherwise specified in these Health Care Administrative Rules. Further, federal EPSDT requirements may require in individual cases exceptions to the general Medicaid program rules.

Health Care Administrative Rules Definitions

1.101 Health Care Administrative Rules Definitions (09/01/2023, GCR 22-107)

For the purposes of these Health Care Administrative Rules, the term:

"Adverse benefit determination" means any of the following
(1) Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements of medical necessity, appropriateness, setting, or effectiveness of a covered service,
(2) Reduction, suspension, or termination of a previously authorized service,
(3) Denial, in whole or in part, of payment for a service,
(4) Failure to provide services in a timely manner, as defined by the Agency of Human Services,
(5) Failure to act within timeframes regarding standard resolution of grievances and appeals,
(6) Denial of a beneficiary's request to obtain services outside the network,
(7) Denial of a beneficiary's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other beneficiary liabilities.

"Agency or AHS" means the Vermont Agency of Human Services or any of its departments, offices, or divisions.

"Beneficiary" means any individual eligible to have benefits paid to them, or on their behalf, under Vermont Medicaid.

"Centers for Medicare and Medicaid Services" or **"CMS"** mean a federal agency within the U.S. Department of Health and Human Services. Programs administered by CMS include Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the federal Health Insurance Marketplace.

"Code of Federal Regulations" or **"CFR"** mean the codification of rules published in the Federal Register by the departments and agencies of the Federal Government.

"Day" means calendar day unless otherwise specified.

"Durable Medical Equipment" or "DME" means equipment and appliances that:
(1) Are primarily and customarily used to serve a medical purpose,
(2) Are generally not useful to an individual in the absence of disability, illness, or injury,
(3) Can withstand repeated use, and
(4) Can be reusable or removable.

"DVHA" means the Department of Vermont Health Access.

"Early and Periodic, Screening, Diagnostic, and Treatment" or **"EPSDT"** mean the items and services defined in 1905(r) of the Social Security Act which include screening, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan.

"Global Commitment to Health Waiver" means a Medicaid Demonstration Waiver authorized by Section 1115 of the Social Security Act, which provides Vermont Medicaid with federally approved waivers of specific requirements of the Social Security Act that would otherwise apply to Vermont Medicaid. These waivers provide Vermont with expenditure and policy authority to expand Medicaid eligibility and to pay for programs and services that promote the objectives of the Medicaid program outside of the Medicaid State Plan.

"Health Care Administrative Rules" or **"HCAR"** mean the collection of rules adopted by the Agency of Human Services that govern the administration of Vermont Medicaid, including general provisions, eligibility, benefit delivery, covered services, reimbursement, specialized services, beneficiary rights, and provider responsibilities.

"HIPAA" means the Health Insurance Portability and Accountability Act, which establishes national standards to protect individuals' medical records and other personal health information.

"Hospital" means a facility that –

(1) is primarily engaged in providing, by or under the supervision of doctors of medicine or osteopathy, inpatient hospital services for the diagnosis, treatment, and care or rehabilitation of persons who are sick, injured, or disabled;
(2) is not primarily engaged in providing skilled nursing care and related services for inpatients who require medical or nursing care;
(3) provides 24-hour nursing service; and
(4) is licensed or approved as meeting the standards for licensing by the State or local licensing agency.

"Human Services Board" means the independent part of AHS that serves as the external appeals entity for compliance with 42 CFR 431, Subpart E, and 3 VSA 3090.

"Medicare" means the health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

"Network" means the providers who are enrolled in Vermont Medicaid and who provide services to beneficiaries.

"Plain Language" means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well organized, and follows best practices of plain language writing for that audience.

"Provider" means any individual or entity who has entered into an agreement with the Agency of Human Services or any of its departments, offices, or divisions, to provide services covered by Vermont Medicaid.

"Provider Manuals" means policy and procedure documents outlining the policies and practices for medical providers enrolled with Vermont Medicaid. Manuals are made publicly available for medical coverage and medical programs administered by the Agency.

"Service Authorization Request" means a request for the provision of a service, including prior authorization and concurrent review, that requires authorization pursuant to 42 CFR 438.210.

"Services" means a benefit (1) covered under the Global Commitment to Health Waiver, (2) included in the Medicaid State Plan, (3) authorized by state rule or other law, (4) required by federal law, or (5) identified in the Intergovernmental Agreement between DVHA and AHS for the administration and operation of the Global Commitment to Health Waiver.

"State Fair Hearing" means an appeal to AHS for a hearing before the Human Services Board.

"State Plan" means the agreement between Vermont and the Centers for Medicare and Medicaid Services approved under Title XIX of the Social Security Act describing how Vermont administers its Medicaid program.

"Vermont Medicaid" means the medical assistance provided under the State Plan approved under Title XIX of the Social Security Act, and the terms and conditions of the Global Commitment to Health Waiver, as approved by CMS.

Telehealth

3.101 Telehealth (5/1/2023, GCR 22-099)

3.101.1 Definitions

For the purposes of this rule, the term:

(a) **"Telehealth"** means methods for health care service delivery using telecommunications technologies. Telehealth includes telemedicine, store and forward, audio-only, and remote patient monitoring.

(b) **"Telemedicine"** means health care delivery by a provider who is located at a distant site to a beneficiary at an originating site for purposes of evaluation, diagnosis, consultation, or treatment, using telecommunications technology via two-way, real-time, audio and video interactive communication, through a secure connection that complies with HIPAA.

(c) **"Store and forward"** means an asynchronous transmission of a beneficiary's medical information from a health care professional or a beneficiary to a provider at a distant site, through a secure connection that complies with HIPAA, without the beneficiary present in real time.

(d) **"Remote Patient Monitoring"** means a health service that enables remote monitoring of a beneficiary's physiological health-related data by a home health agency done outside of a conventional clinical setting and in conjunction with a plan of care ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

(e) **"Originating site"** means the site where the beneficiary is located, whether or not accompanied by a health care provider, when telemedicine, or audio-only services are provided. The originating site may include the beneficiary's home or another nonmedical setting (e.g., school, workplace), a health care provider's office, a facility, or a hospital.

(f) **"Distant site"** means the site where the provider is located, and the beneficiary is not located, when telemedicine, audio-only, or store and forward services are provided.

(g) **"Clinically appropriate"** means clinically accepted standards of medical practice and delivery methods that are considered effective in providing health care services to patients, including for purposes of evaluation, diagnosis, consultation, or treatment.

(h)**"Audio-Only"** means real-time health care delivery by a provider who is located at a distant site to a beneficiary at an originating site for purposes of evaluation, diagnosis, consultation, or treatment, using audio-only telecommunications technology.

3.101.2 Covered Services

(a) Telemedicine:

(1) To be covered, services shall be:

(A) Clinically appropriate for delivery through telemedicine, and
(B) Medically necessary.

(2) Services delivered shall:

(A) Include any service that a provider would typically provide to a beneficiary in a face-to-face setting, and
(B) Adhere to the same program restrictions, limitations, and coverage that exist for the service when not provided through telemedicine.

(b) Store and Forward

(1) To be covered, services shall be:

(A) Clinically appropriate for delivery through store and forward, and
(B) Medically necessary.

(c) Remote Patient Monitoring

(1) To be covered, services shall be:

(A) Clinically appropriate for delivery through remote patient monitoring,
(B) Medically necessary, and
(C) Limited to a Congestive Heart Failure, Hypertension, or Diabetes diagnosis.

(d) Audio-Only

(1) To be covered, services shall be:

(A) Clinically appropriate for delivery through audio-only, and
(B) Medically necessary.

3.101.3 Qualified Providers

Telehealth services must be provided by a provider who is working within the scope of his or her practice and enrolled in Vermont Medicaid.

3.101.4 Beneficiary Eligibility

For remote patient monitoring services, beneficiaries shall:

(a) Have Medicaid as their primary insurance or Medicaid and dually enrolled in Medicare with a non-homebound status,
(b) Have a Congestive Heart Failure, Hypertension, or Diabetes diagnosis,
(c) Be clinically eligible for home health services, and
(d) Have a plan of care with an order for remote patient monitoring services.

3.101.5 Conditions for Coverage

(a) Qualified telemedicine, store and forward, and audio-only providers shall:

(1) Meet or exceed applicable federal and state legal requirements of medical and health information privacy, including compliance with HIPAA.

(2) Provide appropriate informed consent, in a language that the beneficiary understands, consistent with 18 V.S.A. § 9361(c)(1) and 18 V.S.A. § 9362 to include:

(A) Identifying the beneficiary, the provider, and the provider's credentials,
(B) The types of services permitted using telehealth technologies,
(C) A statement that the provider determines whether the conditions being diagnosed and/or treated are appropriate for a telehealth encounter,
(D) Details on security measures taken with the use of telehealth technologies,
(E) Disclosure to the beneficiary that information may be lost due to technical failures,
(F) A statement that the provider will follow all applicable federal and state legal requirements of medical and health information privacy, and
(G) Circumstances under which consent is not required.

(3) Take appropriate steps to establish the provider-patient relationship and conduct all appropriate evaluations and history of the beneficiary consistent with traditional standards of care.

(4) Maintain medical records for all beneficiaries receiving health care services through telehealth that are consistent with established laws and regulations governing patient health care records.

(5) Establish an emergency protocol when care indicates that acute or emergency treatment is necessary for the safety of the beneficiary.

(6) Address needs for continuity of care for beneficiaries (e.g., informing beneficiary or designee how to contact provider or designee and/or providing beneficiary or identified providers timely access to medical records).

(7) If prescriptions are contemplated, follow traditional standards of care to ensure beneficiary safety in the absence of a traditional physical examination.

(b) Qualified remote patient monitoring providers shall:

(1) Use the following licensed health care professionals to review data:

(A) Registered nurse (RN)
(B) Nurse Practitioner (NP)
(C) Clinical nurse specialist (CNS)
(D) Licensed practical nurse (LPN) under the supervision of a RN or physician assistant (PA), and

(2) Follow data parameters established by a plan of care, and

(3) Meet or exceed applicable federal and state legal requirements of medical and health information privacy, including compliance with HIPAA.

3.101.6 Prior Authorization and Documentation Requirements

Services provided through telehealth are subject to the same prior authorization requirements that exist for the service when not provided through telehealth.

3.101.7 Non-Covered Services

(a) Services and procedures that are not covered in a face-to-face setting under Vermont Medicaid are not covered under telemedicine or audio-only.
(b) Services delivered via facsimile, text communication, or electronic mail messages are not considered telehealth and are not covered.

Medical Necessity for Covered Services

4.101 Medical Necessity for Covered Services (07/01/20, GCR 19-060)

4.101.1 Definitions

(a) "**Ameliorate**" means to improve or maintain a beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

(b) "**Generally accepted practice standards**" means standards that are based on:
(1) credible scientific evidence published in peer-reviewed literature,
(2) physician specialty society recommendations, or
(3) the prevailing opinion of licensed health care providers practicing in the relevant clinical area.

(c) "**Medically necessary**" means health care services, including diagnostic testing, preventive services, and aftercare, that are appropriate, in terms of type, amount, frequency, level, setting, and duration, to the beneficiary's diagnosis or health condition, and that:
(1) help restore or maintain the beneficiary's health, or
(2) prevent deterioration or palliate the beneficiary's condition, and
(3) are the least costly, appropriate health service that is available, and
(4) are not solely for the convenience of the beneficiary's caregiver or a provider, and
(5) are supported by documentation in the beneficiary's medical records.

4.101.2 Conditions for Coverage

(a) A health care service that is otherwise covered by Vermont Medicaid is considered medically necessary when the requirements of clinical criteria or guidelines adopted by Vermont Medicaid are met.

(1) Clinical criteria and guidelines adopted by Vermont Medicaid are available on the websites of the departments that are part of the Agency of Human Services.

(2) When the Agency has not adopted clinical criteria or guidelines for a requested service, or the adopted clinical criteria or guidelines are not applicable to the beneficiary, then medical necessity is met if the service is consistent with generally accepted practice standards.

(b) For EPSDT eligible beneficiaries (see Rule 4.106), a determination of medical necessity also includes a case by case determination that a service is needed to correct or ameliorate a diagnosis or health condition or achieve proper growth and development or prevent the onset or worsening of a health condition.

(c) The Agency is the final authority for determinations of medical necessity.

Emergency Services

4.102 Emergency Services (06/01/2018, GCR 17-090)

4.102.1 Definitions

For the purposes of this rule, the term:

(a) **"Emergency Services"** means health care items and services furnished or required to evaluate and treat an emergency medical condition.

(b) **"Post-Stabilization Services"** means health care items and services related to an emergency medical condition that are provided after a beneficiary is stabilized, in order to maintain the stabilized condition.

(c) **"Emergency Medical Condition"** means an illness or medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the beneficiary's physical or mental health, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

4.102.2 Covered Services

Emergency services and post-stabilization services are covered for beneficiaries 24 hours a day, seven days a week.

4.102.3 Conditions for Coverage

Beneficiaries must be within the United States at the time such benefits are needed.

4.102.4 Prior Authorization

Prior Authorization is not required for emergency services.

Medicaid Non-Covered Services

4.104 Medicaid Non-Covered Services (02/22/2018, GCR 17-073)

Vermont Medicaid does not cover certain items and services including:

4.104.1 Cosmetic Services

(a) Any service or procedure performed solely for the purpose of improving appearance is considered cosmetic and is not covered.

(b) Cosmetic Surgery
Cosmetic surgery and expenses incurred in connection with such surgery are not covered. Cosmetic surgery encompasses any surgical procedure directed at improving appearance (including removal of tattoos), except:
(1) When required for the prompt repair of an injury, (e.g., the exclusion does not apply, and payment would be made, for surgery in connection with treatment of severe burns or repair of the face following an auto accident),
(2) Surgery for the improvement of the functioning of a malformed body part, or
(3) Surgery for therapeutic purposes that coincidentally serves some cosmetic purpose.

(c) Prior authorization may be required for surgery performed in 4.104.2(b)(2) and (3).

4.104.2 Experimental or Investigational Medical Services

(a) Medical services that are experimental or investigational are not covered. As used in this section, a service includes a diagnostic service, surgery, treatment, facility, equipment, drug, or device.

(b) A medical service is considered experimental or investigational if:
(1) It is not generally accepted by the professional medical community as established, proven, and effective medical care for the condition, disease, illness, or injury being treated, and
(2) The latest medical and scientific evidence available:
(A) Is insufficient or too inconclusive to permit Medicaid to evaluate if the service is safe and effective, or
(B) Demonstrates that the service is not safe and effective.

(c) Criteria to evaluate medical and scientific evidence, as used in 4.104.3(b)(2) includes:
(1) Credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community,
(2) Current professional practice guidelines and recommendations of professional governing bodies in the medical specialty area, or areas in which the service is applicable or used,
(3) The extent to which Medicare and private health insurers recognize and provide coverage for the service, or
(4) The item or service is approved by the Food and Drug Administration (FDA), if the service or item is FDA regulated.

(d) The specific services that are under investigation as part of a clinical trial are not covered.

4.104.3 Fertility Services

Fertility services and procedures performed in connection with such services are not covered. Non-covered fertility services include, in vitro, the gamete intrafallopian transfer (GIFT) procedure, fertility enhancing drugs, sperm banks, cloning, and services related to surrogacy.

4.104.4 Massage Therapists

Services performed by massage therapists are not covered.

4.104.5 Service Animals

Service animals, and the cost of care for service animals, individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability, are not covered.

4.105 Medicaid Coverage of Exception Requests

4.105.1 General

(A) Beneficiaries who are 21 years old and older may request coverage of a service that Vermont Medicaid has not already determined to be a covered service. The request should be made using the Medicaid Coverage Exception Request process described by this rule.

1. For beneficiaries who are under 21 years old who request coverage of a service that has not already been determined to be covered, Vermont Medicaid will process the request pursuant to the requirements of HCAR 4.106, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services.

(B) Filing an Exception Request; Decision on Exception Request

1. A beneficiary may file an exception request by sending the request and supporting medical documentation to Vermont Medicaid.
2. Vermont Medicaid will make a good faith effort to timely obtain any additional information necessary to determine whether to approve or deny the exception request.
3. The Commissioner of the Department of Vermont Health Access (DVHA) or their designee will make a good faith effort to decide, within thirty days of receipt of the request, to approve or deny the request.

4.105.2 Criteria

(A) The request must be for a beneficiary who is 21 years old or older, and the service must:

1. Fit within a category or subcategory of services described at 42 U.S.C. 1396d(a),
2. Be medically necessary pursuant to HCAR 4.101.1(c),
3. Be necessary due to extenuating circumstances that are unique to the beneficiary such that there would be serious detrimental health consequences if the service was not provided, and
4. Have not been reviewed and denied approval by the Federal Drug Administration (FDA), if the service is subject to FDA approval.

(B) If the requirements of 4.105.2(A) are met, the Commissioner of DVHA or their designee will consider the following additional criteria, in combination, in determining whether to approve or deny coverage of the service:

1. The service has not been identified in administrative rule or statute as a non-covered service, or, if the service has been identified as non- covered and a reason for its non-coverage includes its lack of efficacy, then there has been credible and material new evidence about the efficacy of the service since it was identified as non-covered.
2. The service fits within a category or subcategory of services described at 42 U.S.C. 1396d(a) that is offered by Vermont Medicaid for adults,
3. The service is consistent with the objective of the Medicaid Act (Title XIX of the Social Security Act), to provide medical assistance to eligible individuals.
4. Denial of the service would be arbitrary. Vermont Medicaid may not deny coverage for a service solely based on its cost.
5. The service is not experimental or investigational.
6. The medical appropriateness and efficacy of the service has been demonstrated in credible scientific evidence published in peer-reviewed literature or by medical experts in the relevant clinical field.
7. Less expensive, medically appropriate alternatives are not available, or have been trialed and failed,

or are contraindicated for the beneficiary.

8. The service is primarily and customarily used to serve a medical purpose, and it is generally not useful to an individual in the absence of an illness, injury, or disability.
9. If the request is for a brand-name prescription drug that is not covered because the drug manufacturer does not participate in the Federal Drug Rebate Program, then coverage of this drug must be needed because the currently covered drug has not been effective in treating the beneficiary's medical condition or causes or is reasonably expected to cause adverse or harmful reactions in the beneficiary.

4.105.3 Outcomes

(A) The Commissioner or their designee will approve or deny coverage of the service for the beneficiary.

(B) For approvals and denials in the exception request process, the Commissioner or their designee will determine whether to pursue administrative processes (e.g., state plan amendment, administrative rule) that are necessary to cover the service by Vermont Medicaid.

4.105.4 Approvals

(A) Annually, Vermont Medicaid will publish on the DVHA website a document updating the list of the approved coverage decisions made under the exception request process that do not result in the service being considered for pursuit of coverage by Vermont Medicaid, as described at 4.105.3(B).

(B) Vermont Medicaid will ensure that all Medicaid beneficiaries who are similarly situated to the individual who has obtained coverage pursuant to the exceptions request process are treated similarly with respect to coverage of the same service.

4.105.5 Adverse Decisions

(A) Vermont Medicaid will inform a beneficiary who receives an adverse decision of their right to appeal through the State fair hearing process.

(B) A request for a service for which there has been an adverse decision may not be renewed by the same beneficiary until twelve months have elapsed since the previous final decision or until one of the following has been demonstrated:

1. New documentation of the individual's condition that was not available at the time of the prior request,
2. A material change in the individual's condition,
3. New and material medical evidence, or
4. A material change in technology has been demonstrated.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

4.106 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services (07/01/2020; GCR # 19-060)

4.106.1 Introduction

Vermont Medicaid covers Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for Medicaid beneficiaries under 21 years old pursuant to Section 1905(r) of the Social Security Act (42 USC 1396d(r)). Vermont Medicaid covers as EPSDT services those services that are within the scope of the category of services listed in Section 1905(a) of the Social Security Act (42 USC 1396d(a)) and that are medically necessary, whether or not the service is covered by the Vermont Medicaid State Plan.

4.106.2 Definitions

(a) "**EPSDT eligible beneficiaries**" means Medicaid beneficiaries (not including beneficiaries with limited Medicaid coverage) under 21 years old.
(b) "**EPSDT services**" means services that are within the scope of category of services described as "medical assistance" at Section 1905(a) of the Social Security Act (42 USC 1396d(a)), regardless of whether the service is listed in the Medicaid State Plan or administrative rule, and regardless of whether the service is covered or has limitations for Medicaid beneficiaries 21 years old and older.

4.106.3 Informing

(a) Vermont Medicaid will:
(1) Inform EPSDT eligible beneficiaries of the availability of EPSDT services within 60 days of a beneficiary being enrolled in Medicaid, and
(2) Annually inform EPSDT eligible beneficiaries who have not used EPSDT services within the prior year of the availability of EPSDT services.

(b) When informing EPSDT eligible beneficiaries of the availability of EPSDT services, Vermont Medicaid will inform the beneficiary:
(1) The benefits of preventive health care,
(2) The services that are available under EPSDT,
(3) How to access EPSDT services, and
(4) The availability of transportation and scheduling assistance if necessary to access EPSDT services.

4.106.4 Screening

(a) Vermont Medicaid covers medical, vision, dental, and hearing screenings for EPSDT eligible beneficiaries, at intervals based on medical/dental practice standards determined in consultation with recognized medical and dental organizations involved in child health care, and on an interperiodic basis, as needed, in order to identify and treat health conditions early.

(1) Vermont Medicaid will implement a periodicity schedule for screening services that specifies screening services applicable at each stage of the EPSDT eligible beneficiary's life, beginning with neonatal examination, up to the age that a beneficiary is no longer eligible for EPSDT.

(b) Vermont Medicaid covers medical screenings that include a comprehensive health and developmental history that assesses for physical, mental and developmental health and substance use disorders, a comprehensive physical examination, appropriate immunizations and laboratory tests (including lead blood level tests), and

health education for both the EPSDT eligible beneficiary and, where appropriate, their caregiver.

4.106.5 Diagnostic and Treatment Services

(a) Vermont Medicaid covers diagnostic services without delay to an EPSDT eligible beneficiary when a screening indicates a need for further evaluation.

(b) Vermont Medicaid covers EDPST services that are medically necessary, as defined by Rule 4.101.

(1) Vermont Medicaid covers all medically necessary services for EPSDT eligible beneficiaries without regard to service limitations otherwise specified in these Health Care Administrative Rules.
(2) Vermont Medicaid will determine medical necessity on a case by case basis, based on the needs of the EPSDT eligible beneficiary.

(c) Vermont Medicaid may approve a cost effective alternative to the requested EPSDT service provided the alternative is equally effective and available.

4.106. 6 Qualified Providers

(a) EPSDT services may be delivered by a variety of providers. The provider must be:

(1) Enrolled in Vermont Medicaid,
(2) Within the limits established by Section 1905(a) of the Social Security Act (42 USC 1396d(a)), and
(3) Working within the scope of their practice.

4.106.7 Prior Authorization

Fee Schedules, including for EPSDT services covered by the Agency of Human Services, contain detailed lists of covered procedures and services and indicate which of these require prior authorization. Fee Schedules can be found on the Department of Vermont Health Access website.

4.106.8 Non-covered Services

(a) Services that cannot be covered as a category of services pursuant to Section 1905(a) of the Social Security Act (42 USC 1396d(a)) are not covered.

(b) See Rule 4.104 for additional Medicaid non-covered services.

4.200 Inpatient Hospital Services (09/01/2023, GCR 22-107)

4.200.1 Definitions

The following definitions shall apply for use in 4.200:

(a) **Inpatient** means a Vermont Medicaid beneficiary who has been admitted to a medical institution as an inpatient on recommendation of a physician, naturopathic physician, dentist, or other qualified practitioner with admitting privileges and who –
  (1) Receives room, board, and professional services in the institution for a 24-hour period or longer, or
  (2) Is expected by the institution to receive room, board, and professional services in the institution for a 24-hour period or longer even though it later develops that the patient dies, is discharged, or is transferred to another facility and does not actually stay in the institution for 24 hours.

(b) **Inpatient hospital services** means services that:
  (1) are ordinarily furnished in a hospital for the care and treatment of inpatients;
  (2) are furnished under the direction of a physician, naturopathic physician, or dentist;
  (3) are furnished in a hospital that is maintained primarily for the care and treatment of patients with disorders other than mental diseases and meets the requirements for participation in Medicare as a hospital; and
  (4) do not include skilled nursing facility and intermediate care facility services furnished by a hospital with a swing-bed approval.

4.200.2 Covered Services

(a) Inpatient hospital services are covered by Vermont Medicaid according to the conditions for coverage at section 4.200.3 of this rule.

(b) Inpatient psychiatric services provided in a hospital that is maintained primarily for the care and treatment of patients with disorders other than mental diseases are covered to the same extent as inpatient hospital services related to any other type of care or treatment.

(c) Drugs furnished by the hospital as part of inpatient care and treatment, including drugs furnished in limited supply to permit or facilitate discharge from a hospital to meet the patient's requirements until a continuing supply can be obtained, are covered.

4.200.3 Conditions for Coverage

(a) Coverage for inpatient hospital services is limited to those instances in which the admission and continued stay of the beneficiary are determined medically necessary by the appropriate utilization review authority.

(b) Inpatient hospital services are covered at hospitals included in the Vermont Medicaid provider network.

(c) Coverage for hospitals outside of the Vermont Medicaid provider network is only available if:

(1) an out-of-network hospital is approved either for Medicare participation or for Medical Assistance (Title XIX) participation by the single state agency administering the Title XIX program within the state where it is located; and
(2) the admission receives any required prior authorization as described in Section 4.200.4 of this rule.

(d) The current list of hospitals included in the Vermont Medicaid provider network is located on the Department of Vermont Health Access web site.

(e) Coverage may also be extended for inpatients who are determined no longer in need of hospital care but have been certified for care in a nursing facility (Medicaid Rule 7606), behavioral health facility, or other specialized treatment center.

4.200.4 Prior Authorization Requirements

(a) Elective inpatient admissions may require prior authorization at certain hospitals prior to the provision of services. Clinical prior authorization forms and the list of hospitals that require prior authorization for elective inpatient admissions can be found on the Department of Vermont Health Access website.

(b) Prior authorization is not required for emergent and urgent inpatient care, however, notification to Vermont Medicaid is required within 24 hours of admission or the next business day. Emergency services are defined in Health Care Administration Rule 4.102.

4.200.5 Non-Covered Services

(a) The following inpatient hospital services are excluded from coverage:
(1) Private room at patient's request for their personal comfort;
(2) Personal comfort items such as telephone, radio, or television in hospital room;
(3) Private duty nurses; and
(4) Experimental treatment and other non-covered procedures.

Outpatient Hospital Services

4.201 Outpatient Hospital Services (09/01/2023, 22-107)

4.201.1 Definitions

For the purposes of this rule, the term:

(a) **Outpatient** means a Vermont Medicaid beneficiary who is a patient of a hospital or distinct part of that hospital who is expected by the hospital to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the hospital past midnight.

(b) **Outpatient hospital services** means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to outpatients by or under the direction of a physician, naturopathic physician, or dentist; and are furnished by an institution that meets the definitions of "hospital" in Health Care Administrative Rule 1.101 - Definitions.

4.201.2 Covered Services

(a) Outpatient hospital services are covered by Vermont Medicaid according to the conditions for coverage at section 4.201.3 of this rule.

4.201.3 Conditions for Coverage

(a) Use of the emergency room at any time is limited to instances of emergency medical conditions, as defined in Health Care Administrative Rule 4.102.1(c).

4.201.4 Prior Authorization Requirements

(a) The Vermont Medicaid Fee Schedule contains a detailed list of covered services and indicates which services require prior authorization. The Fee Schedule can be found on the Department of Vermont Health Access website.

(b) Elective outpatient hospital services may require prior authorization at certain hospitals prior to the provision of services. The list of hospitals that require prior authorization for elective outpatient hospital services can be found on the Department of Vermont Health Access website.

4.201.5 Non-Covered Services

(a) Diagnostic testing, such as a court-ordered test, that is not medically necessary, as defined in Health Care Administrative Rule 4.101, is not covered.

Dental Services for Beneficiaries Age 21 and Older

4.202 Dental Services for Beneficiaries Age 21 and Older (05/12/17, GCR 16-120)

4.202.1 Definitions

For the purposes of this rule, the term:

(a) **"Dental services"** mean preventive, diagnostic, or corrective procedures including the treatment of:

(1) The teeth and associated structures of the oral cavity, and
(2) Disease, injury, or impairment that may affect the oral or general health of the beneficiary.

(b) **"Dentist"** means an individual licensed to practice dentistry or dental surgery.

4.202.2 Covered Services

Coverage of dental services for beneficiaries age 21 and older is limited to medically necessary dental services.

4.202.3 Eligibility for Care

(a) Beneficiaries age 21, and older, are eligible for dental services under this rule.

(b) Dental services for pregnant and postpartum women, and/or beneficiaries under the age of 21, are covered under Rule 4.203 Dental Services for Beneficiaries Under Age 21, and Pregnant and Postpartum Women.

4.202.4 Qualified Providers

Dental services must be provided by, or under the supervision of, a licensed dentist enrolled in Vermont Medicaid and working within the scope of his or her practice.

4.202.5 Conditions for Coverage

(a) Periodic prophylaxis, including topical fluoride application, is limited to once every six months. More frequent treatments require prior authorization by the Department of Vermont Health Access.

(b) Non-surgical treatment of temporomandibular joint (TMJ) disorders is limited to the fabrication of an occlusal orthotic appliance (TMJ splint).

(c) Local anesthesia is covered as part of the dental procedure and shall not be separately reimbursable.

(d) Pulp capping and bases are covered as incidental to a restoration and shall not be separately reimbursable.

4.202.6 Conditions for Reimbursement

(a) Coverage of dental services for beneficiaries age 21 or older is limited to a maximum dollar amount of $510 per beneficiary per calendar year.

(b) The Department of Vermont Health Access publishes and periodically updates a Dental Procedures

Fee Schedule which sets the fees reimbursable under the Medicaid program and lists procedures excluded from the maximum dollar amount.

(c) Medical and surgical services of a dentist, as described in Rule 4.204, are not subject to the maximum dollar amount.

(d) Providers may bill a beneficiary for procedures after the maximum annual dollar amount for services has been reached, or for procedures not covered by Vermont Medicaid.

(e) Providers shall follow these conditions when billing a beneficiary:

(1) Billed amounts may not exceed the appropriate procedure rate in the Dental Procedures Fee Schedule. This condition does not apply to procedures that are not covered by Vermont Medicaid.
(2) Providers shall acquire written acknowledgement of financial liability from a beneficiary prior to performing the procedure.

4.202.7 Prior Authorization Requirements

The Dental Procedures Fee Schedule contains a detailed list of covered dental procedures and services and indicates which require prior authorization. The Dental Procedures Fee Schedule can be found on the Department of Vermont Health Access website.

4.202.8 Non-Covered Services

Services that are not covered include: procedures for cosmetic purposes; and certain elective procedures, including but not limited to: bonding, sealants, periodontal surgery, comprehensive periodontal care, orthodontic treatment, processed or cast crowns and bridges.

Dental Services for Beneficiaries Under Age 21, and Pregnant and Postpartum Women

4.203 Dental Services for Beneficiaries Under Age 21, and Pregnant and Postpartum Women (05/12/2017, GCR 16-120)

4.203.1 Definitions

For the purposes of this rule, the term:

(a) "**Dental services"** means preventive, diagnostic, or corrective procedures, including treatment of:

(1) The teeth and associated structures of the oral cavity, and
(2) Disease, injury, or impairment that may affect the oral or general health of the beneficiary.

(b) **"Dentist"** means an individual licensed to practice dentistry or dental surgery.

4.203.2 Covered Services

Coverage is available for all medically necessary dental services.

4.203.3 Eligibility for Care

Dental services for medically necessary purposes are covered for beneficiaries who are:

(a) Under the age of 21, or
(b) Pregnant through the duration of their pregnancy and through the end of the calendar month during which the 60th day following the end of pregnancy occurs.

4.203.4 Qualified Providers

Dental services must be provided by, or under the supervision of, a licensed dentist enrolled in Vermont Medicaid and working within the scope of his or her practice.

4.203.5 Conditions for Coverage

(a) Periodic prophylaxis, including topical fluoride is limited to once every six months, except more frequent treatments can be prior authorized by the Department of Vermont Health Access.

(b) Non-surgical treatment of temporomandibular joint disorders (TMJ) is limited to the fabrication of an occlusal orthotic appliance otherwise known as a TMJ splint.

(c) Local anesthesia is covered as part of the dental procedure and shall not be separately reimbursable.

(d) Pulp capping and bases are covered as incidental to a restoration and shall not be separately reimbursable.

4.203.6 Prior Authorization Requirements

The Dental Procedure Fee Schedule contains a detailed list of covered dental procedures and services and indicates which require prior authorization. The fee schedule can be found on the Department of Vermont Health Access website.

4.203.7 Non-Covered Services

Services that are not medically necessary, to include procedures solely for cosmetic purposes and certain elective procedures are not covered.

Medical and Surgical Services of a Dentist

4.204 Medical and Surgical Services of a Dentist (05/26/2017, GCR 16-120)

4.204.1 Definitions

For the purposes of this rule, the term:

"Medical and surgical services of a dentist" means those services furnished by a doctor of dental medicine or dental surgery if the services are services that:

(a) If furnished by a physician, would be considered physician services,
(b) May be furnished by either a physician or a doctor of dental medicine or surgery, and
(c) Are furnished by a licensed doctor of dental medicine or dental surgery working within the scope of his or her practice and enrolled in Vermont Medicaid.

4.204.2 Covered Services

Covered medical and surgical services of a dentist include but are not limited to:

(a) Biopsies,
(b) Repair of lacerations,
(c) Excision of a cyst or tumor,
(d) Reconstructive surgery,
(e) Reduction of a fracture,
(f) Repair of temporomandibular joint dysfunction, including surgical treatment,
(g) Problem-focused limited oral evaluation,
(h) Problem-focused limited re-evaluation,
(i) Incision and drainage of abscess,
(j) Emergency treatment of dental pain.

4.204.3 Conditions for Coverage

(a) Maxillofacial surgery must be provided by a licensed physician or dentist working within the scope of his or her practice and enrolled in Vermont Medicaid.

(b) Medical and surgical services of a dentist are covered as hospital and/or physician services and subject to the applicable limitations found in rules 7201, Inpatient Services, 7203, Outpatient Services, and 7301, Physicians and Other Licensed Practitioners.

(c) Medical and surgical services of a dentist are not subject to the adult dental services $510 annual maximum benefit.

(d) Tooth repair and replacement or other services billed as dental procedures that are a medically necessary part of surgery are covered under the dental benefit and subject to the limitations of Dental Services rules 4.202 and 4.203 as applicable.

4.204.4 Prior Authorization Requirements

Prior authorization may be required, except in cases of emergency medical and surgical services.

Orthodontic Treatment

4.205 Orthodontic Treatment (05/12/2017, GCR 16-120)

4.205.1 Definition

For the purposes of this rule, the term:

(a) **"Orthodontic treatment"** means the use of one or more prosthetic devices to correct or prevent a severe malocclusion.

(b) **"Limited orthodontic treatment"** means orthodontic treatment with a limited objective, not necessarily involving the entire dentition.

(c) **"Interceptive orthodontic treatment"** means treatment before a malocclusion has fully developed.

(d) **"Comprehensive Orthodontic Treatment"** means treatment for major or minor malocclusions.

4.205.2 Covered Services

Medically necessary orthodontic treatments include but are not limited to the following categories:

(a) Limited orthodontic treatment,
(b) Interceptive orthodontic treatment,
(c) Comprehensive orthodontic treatment, and
(d) Orthodontic treatment to control harmful habits.

4.205.3 Eligibility for Care

Medically necessary orthodontic treatments are covered for beneficiaries who are:

(a) Under the age of 21 or;
(b) Pregnant through the duration of their pregnancy and through the end of the calendar month during which the 60th day following the end of pregnancy occurs.

4.205.4 Qualified Providers

Orthodontic treatment must be provided by a licensed dentist working within the scope of his or her practice and enrolled in Vermont Medicaid.

4.205.5 Conditions for Coverage

(a) Coverage for comprehensive orthodontic treatment is limited to those that are medically necessary to correct a minimum of one major or two minor malocclusions according to diagnostic criteria adopted by the Department of Vermont Health Access. Or if a beneficiary has a functional impairment that is equal to or greater than the severity of a functional impairment meeting the diagnostic criteria.

(b) Orthodontic treatments for cosmetic purposes are not covered.

4.205.6 Prior Authorization Requirements

Prior authorization is required for all orthodontic treatment.

4.207 Prescribed Drugs (11/1/2019, GCR 19-021)

4.207.1 Definitions

For the purposes of this rule, the term:

(a) **"Good cause and hardship"** means an instance where the lack of coverage cannot reasonably be considered the fault of the individual, and includes circumstances where alternative means for the coverage at issue are not reasonably available and will likely result in irreparable loss or serious harm to the individual.

(b) **"Maintenance drug"** means a drug approved by the federal Food and Drug Administration (FDA) for use longer than 30 days and prescribed to treat a chronic condition. Coverage of maintenance drugs is subject to the Preferred Drug List and limited to the current list of covered drugs designated by Medicaid as maintenance. A list of maintenance drugs is posted on the DVHA website.

4.207.2 Covered Services

Coverage for prescribed drugs is provided in accordance with section 1927 of the Social Security Act, Covered Outpatient Drugs.

(a) Preferred Drug List

Coverage of all drugs is subject to the requirements of the Preferred Drug List (PDL), which is available on the DVHA website.

(b) Non-Drug Items

Coverage is provided for vaccines, diabetic supplies, spacers, and peak flow meters, subject to the requirements of the PDL.

(c) Over-the-Counter Drugs

Over-the-counter (OTC) drug coverage is subject to the requirements of the PDL and must be prescribed as part of the medical treatment of a specific disease.

(d) Prescription Vitamins and Minerals

The following vitamins and minerals for which the FDA requires a prescription are covered:
(1) Select prenatal vitamins for pregnant and lactating women, and
(2) Single vitamins or minerals when prescribed for the treatment of a specific vitamin deficiency or disease related to a vitamin deficiency.

(e) Compounded Drugs

Some ingredients and excipients used in extemporaneously compounded prescriptions are covered when dispensed by a participating pharmacy and issued by a licensed prescriber following state and federal laws. Bulk powders, also known as Active Pharmaceutical Ingredients (APIs), are used for compounding drugs and are subject to prior authorization. A list of covered APIs and excipients is available on the DVHA website.

4.207.3 Eligibility for Care

(a) Beneficiaries enrolled in Vermont Medicaid are eligible for prescribed drug coverage as described in this rule.

(b) The following applies to individuals who are eligible for both a Medicare prescription drug benefit and Medicaid (i.e. "dual eligible"):

(1) Dual eligible individuals are not eligible for Medicaid prescribed drug coverage as described in this rule, except for those drug classes below for which Medicare drug coverage is not available.
(A) Drugs for anorexia or weight gain, subject to the PDL,
(B) Single vitamins or minerals if the conditions described in rule 4.207.2(d)(2) are met, and
(C) Over-the-counter drugs if the conditions described in rule 4.207.2(c) are met.

(2) Dual eligible individuals may request coverage of a prescribed drug when an individual has exhausted the appeal process under the Medicare prescription drug benefit.

(c) For Medicaid beneficiaries who are eligible for and have applied for the Medicare prescription drug benefit but have not yet received coverage due to an operational problem with Medicare, or who otherwise have not received coverage for a needed drug: Vermont Medicaid will cover the drug if medically necessary and if it finds that good cause and hardship exist. Coverage will continue until the operational problem and good cause and hardship ends. The individual must have made every reasonable effort with Medicare, given the individual's circumstances, to obtain coverage.

4.207.4 Qualified Providers

Payment for prescribed drugs is limited to Vermont Medicaid enrolled providers who are:

(a) Licensed Vermont pharmacies, including outpatient hospital pharmacies, operating within their scope of practice; or

(b) Pharmacies appropriately licensed in another state, operating within their scope of practice; or

(c) A licensed physician serving a rural area without an available pharmacy, who has been granted special approval prior to July 1, 2019 to bill these items directly and is operating within their scope of practice.

4.207.5 Conditions for Coverage

(a) Payment is limited to covered items with a valid prescription from a medical professional licensed by the state of Vermont to prescribe within the scope of their practice and enrolled in Vermont Medicaid. The prescription must

be dispensed by a qualified provider in accordance with applicable federal and state statutes and regulations and must be for the Medicaid member only.

(b) Up to eleven refills are permitted if allowed by federal and state statutes and regulations.

(c) Supply Limits

(1) Maintenance drugs must be prescribed and dispensed for not less than 30 days and not more than 102 days. Select drugs used for maintenance treatment must be prescribed and dispensed for a minimum of a 90-day supply. This limit shall not apply for the first two fills of the prescription. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period, a prior authorization for waiver of the 90-day supply requirement may be filed. A list of select maintenance drugs that require a minimum 90-day supply can be found on the DVHA website.

(2) Contraceptives, at the discretion of the prescriber, may be dispensed by a pharmacist in an amount intended to last up to a 12-month duration.

(3) A pharmacist shall not fill a prescription in a quantity greater than that prescribed, except in an individual case when the quantity has been changed on the prescription in consultation with the prescriber.

(d) Unused Drugs

(1) Except for controlled substances, unused or unit-dose medication that is in reusable condition, and which may be returned to a pharmacy pursuant to state laws, rules or regulations, shall be returned from long-term care facilities to the provider pharmacy.

(2) When the primary payer is Vermont Medicaid, all returned medications must be credited to Vermont Medicaid.

4.207.6 Prior Authorization Requirements

(a) Vermont Medicaid maintains a PDL, which is available on the DVHA website. All drugs and non-drug items are subject to the requirements of the PDL. Some preferred and all non-preferred drugs are subject to prior authorization as described in the PDL.

(b) An emergency fill can be dispensed when a required prior authorization has not been secured and the need to fill the prescription is determined to be a medical emergency. If the prescriber or covering prescriber cannot be reached to obtain the required prior authorization, the pharmacist may dispense an emergency supply to last up to 72 hours. A prior authorization will still be needed for further dispensing. 72-hour emergency fills do not qualify as “started and stabilized” on the Medicaid PDL.

(c) Supply limits in excess of those described in 4.207.5(c) require prior authorization and are subject to approval by the DVHA Medical Director.

Medical Supplies

4.208 Medical Supplies (08/01/2021, GCR 21-016)

4.208.1 Definition:

(a) **"Medical supplies"** means health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness, or injury.

This definition is in accordance with 42 CFR §440.70(b)(3)(i).

4.208.2 Covered Services

(a) Medical supplies are covered when medically necessary.

(b) General categories of covered supplies include:

- Catheter supplies
- Diabetic supplies
- Incontinence supplies: including briefs, diapers, and underpads
- Irrigation supplies
- Ostomy care supplies: including adhesives, irrigation supplies, and bags
- Respiratory and tracheostomy care supplies, and
- Wound care supplies including dressings, gauze pads, tape, and rolls

(c) Vermont Medicaid publishes and maintains a list of pre-approved supplies and their quantity limits. The list is publicly available on the Department of Vermont Health Access website. Supplies that are not pre-approved are subject to prior authorization review. Quantity limits may be exceeded when medically necessary, with prior authorization.

4.208.3 Qualified Providers

(a) Medical supplies must be ordered by a provider who is enrolled in Vermont Medicaid and working within the scope of their practice.

(b) Providers of medical supplies must be enrolled in Vermont Medicaid.

4.208.4 Conditions for Coverage

(a) Medical supplies must be necessary to address a beneficiary's medical condition, as ordered by a Medicaid enrolled medical provider.

(b) Supplies may be suitable for use in any setting in which normal life activities take place. Coverage is not restricted to supplies that are used in the home.

(c) The face-to-face requirements in Health Care Administrative Rule 4.209 Durable Medical Equipment apply to medical supplies that are also subject to the face-to-face requirement under Medicare.

(d) These conditions for coverage do not apply to medical supplies reimbursed as a component of an institutional payment.

4.208.5 Prior Authorizations

(a) Ordering providers must provide pertinent diagnostic and clinical data to support a prior authorization request.

4.208.6 Non-Covered Services

(a) Supplies intended for convenience, comfort, or personal hygiene, that are not primarily used for a medical purpose to address a medical disability, illness, or injury, are not covered.

(b) Routine medical supplies used during the usual course of treatment in a medical office visit or home health visit are not reimbursed separately.

Durable Medical Equipment

4.209 Durable Medical Equipment (01/07/2019, GCR 18-037)

4.209.1 Definitions

"Durable Medical Equipment" (DME) means equipment and appliances that:

(a) Are primarily and customarily used to serve a medical purpose,
(b) Are generally not useful to an individual in the absence of disability, illness, or injury,
(c) Can withstand repeated use, and
(d) Can be reusable or removable.

This definition is in accordance with the federal Medicaid definition of equipment and appliances found at 42 CFR§440.70(b)(3)(ii).

4.209.2 Covered Services

(a) Vermont Medicaid publishes and maintains a list of pre-approved items of DME. Items of DME that are not pre-approved are subject to prior authorization review.

4.209.3 Qualified Providers and Vendors:

(a) DME vendors must be enrolled in Vermont Medicaid.

(b) DME must be ordered by a provider who is enrolled in Vermont Medicaid and working within the scope of his or her practice.

(c) The following non-physician practitioners (NPP) may perform the face-to-face encounter as required in 4.209.4(b) of this rule:
(1) A nurse practitioner or clinical nurse specialist working in collaboration with the ordering physician, or
(2) A physician assistant under the supervision of the ordering physician.

(d) For beneficiaries requiring DME immediately after an acute or post-acute stay, the attending acute or post-acute physician may perform the face-to-face encounter.

4.209.4 Conditions for Coverage

(a) DME is covered when it is medically necessary. Medical necessity includes when the item is necessary to perform activities of daily living. Orders for DME must include sufficient information to document the medical necessity of the item being prescribed.

(b) For the initiation of DME that requires a face-to-face encounter, pursuant to 4.209.4(b)(3), a qualified provider must conduct a face-to-face encounter with the beneficiary no more than six months prior to the start of service.

(1) The face-to-face encounter must be related to the primary reason the beneficiary requires DME.

(2) The face-to-face encounter may be conducted in person or through telemedicine.

(3) For Vermont Medicaid, the face-to-face requirement only applies to items of DME that are also subject to the face-to-face requirement under Medicare.

(4) Documentation of the face-to-face visit shall include:

(A) That the face-to-face encounter is related to the primary reason the beneficiary requires DME,
(B) That the face-to-face encounter occurred within the required timeframe,
(C) The practitioner who conducted the encounter, and
(D) The date of the encounter.

(5) When DME is ordered with a home health services plan of care, the NPP performing the face-to-face encounter must communicate the clinical findings of that face-to-face encounter to the physician ordering the home health services. Those clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.

(c) DME may be suitable for use in any setting in which normal life activities take place. Coverage is not restricted to DME that is used in the home.

(d) DME shall be rented or purchased based upon the beneficiary's condition and the period of time the equipment will be required. The total cost of the rental shall not exceed the total value of the item. DVHA publishes and maintains a list of rented DME.

(e) DME providers are expected to maintain adequate and continuing service and support for Medicaid beneficiaries.

(f) Replacement of DME will be authorized when changing circumstances or conditions are sufficient to justify replacement with an item of different size or capacity, when the useful lifetime has been reached, or when the device no longer safely addresses the medical needs of the beneficiary and can no longer be repaired.

(g) Vermont Medicaid is the owner of all purchased equipment. Such equipment shall not be resold. Serviceable DME may be recovered for reuse or recycling when the beneficiary no longer needs it. The beneficiary shall notify Vermont Medicaid when serviceable equipment is no longer needed or appropriate for the beneficiary.

(h) The conditions of coverage do not apply to items reimbursed as a component of an institutional payment.

Wheelchairs, Mobility Devices, and Seating Systems

4.210 Wheelchairs, Mobility Devices, and Seating Systems (01/07/2019, GCR 18-037)

4.210.1 Definitions

(a) **"Wheelchairs and Mobility Devices"** means items of durable medical equipment (DME) that enable mobility for beneficiaries with a significant impairment in the ability to functionally ambulate. A mobility device, including a power operated vehicle, is an item that serves the same purpose as a wheelchair.

(b) **"Functional Ambulation"** means the ability to walk with or without the aid of a device such as a cane, crutch, or walker for medically necessary purposes as defined in 4.210.2(b).

(c) **Mobility-Related Activities of Daily Living (MRADL)"** means activities such as toileting, feeding, dressing, grooming, and bathing.

(d) **"A Mobility Limitation that significantly impairs a beneficiary's ability to participate in one or more MRADL"** means a limitation that:

(1) Prevents the beneficiary from accomplishing an MRADL entirely, or
(2) Places the beneficiary at heightened risk of morbidity or mortality when attempting to perform an MRADL, or
(3) Prevents the beneficiary from completing an MRADL within a reasonable time frame.

(e) **"Customize"** means making significant alterations or modifications to a component that are not anticipated in the manufacturer's design, or require fabrication of another component or hardware in order to adapt the equipment to a beneficiary or to the wheelchair.

4.210.2 Covered Services

(a) Wheelchairs, mobility devices, seating systems, and related services are covered when medically necessary.

(b) Wheelchairs and mobility devices are considered medically necessary when a beneficiary has a mobility limitation that significantly impairs his/her ability to:

(1) Participate in one or more MRADLs in or outside of the home,
(2) Access authorized Medicaid transportation to medical services, or
(3) Exit the home within a reasonable timeframe.

(c) Rental of Wheelchairs and Mobility Devices

(1) Payment will be made for rental of one device under the following circumstances:

(A) While waiting for purchase or repair of a custom chair, when there is no other available option,
(B) For short-term acute medical conditions,
(C) During a trial period, or
(D) As part of Medicaid reimbursement requirements for items of DME subject to capped rental.

(d) Non-Customized Manual Wheelchairs

(1) Payment will be made for non-customized manual wheelchairs for beneficiaries who have documented long-

term medical needs.

(e) Custom Wheelchairs and Mobility Devices

(1) Payment will be made for a customized manual wheelchair, a power wheelchair, a power-operated vehicle, or other mobility device when a beneficiary's MRADLs cannot be accomplished by the provision of a non-customized manual chair.

(f) Second Wheelchair or Mobility Device

(1) Payment is limited to one primary piece of equipment, except when a beneficiary with a power wheelchair needs a manual wheelchair when medically necessary.

(g) Replacement Wheelchair or Mobility Device

(1) Payment will be made for replacement wheelchairs or mobility devices for:

(A) Beneficiaries with specific documented growth needs,
(B) Beneficiaries with a change in medical status that necessitates replacement,
(C) For loss, or
(D) Replacement when, as a result of normal wear and tear, the wheelchair or device no longer safely addresses the medical needs of the beneficiary and can no longer be repaired.

(h) Seating Systems

(1) Covered items are manufactured seating systems, and seating systems that have been custom-fabricated or customized by the DME provider, for use in a wheelchair. A seating system must contain a seat and/or back with one other positioning component.

(2) Reimbursement for up to five hours of labor associated with custom fabrication of a seating system or customizing a seating system will be made to the DME provider.

(i) Repair to damaged or worn equipment is covered when the equipment is not under warranty.

4.210.3 Qualified Providers and Vendors

(a) Providers must be licensed, working within the scope of his or her practice and enrolled in Vermont Medicaid.

(b) Vendors must be Medicaid enrolled providers of durable medical equipment.

4.210.4 Conditions for Coverage

(a) The requirements in rule 4.209 Durable Medical Equipment apply to wheelchairs.

(b) Payment will be made for seating systems, and/or any required accessories, for beneficiaries residing in a long term-care facility when the system is so uniquely constructed or substantially modified to the individual that it would not be useful to other residents.

(c) When Vermont Medicaid has purchased a seating system for an individual residing in a long-term care facility and that individual moves to a new living arrangement, Vermont Medicaid will purchase from the facility, at the net book value, the components of the wheelchair purchased by the facility.

(d) When a beneficiary who resides in a long-term care facility moves to a new living arrangement and requires a wheelchair that is not available in the new residence, Vermont Medicaid will authorize coverage for a new wheelchair, or purchase, at the net book value, the wheelchair provided by the facility from which the individual moved.

4.210.5 Prior Authorization Requirements

(a) Prior authorization is required for the purchase, rental, or replacement of wheelchairs and mobility devices.

(b) Prior authorization is required for wheelchair repairs costing more than $500. Equipment guarantees and warranties must be utilized before billing Medicaid.

(c) Prior authorization is required for the labor cost of repairs where parts are under warranty.

4.210.6 Non-Covered Services

(a) A wheelchair or mobility device is not covered when used as transportation that otherwise could be accomplished in a vehicle.

(b) Payment will not be made for:

(1) Custom-colored wheelchairs or accessories,
(2) Cushions that are not an integral component of the wheelchair,
(3) Costs associated with repair or adjustments to the original wheelchair and related items under implied or expressed warranties, other than labor costs where parts are under warranty, or
(4) DME supplier's costs associated with fitting and/or evaluation of a seating system. These costs are included in the initial reimbursement for the item.

Augmentative Communication Devices and Systems

4.211 Augmentative Communication Devices and Systems (06/20/2017, GCR 17-013)

4.211.1 Definitions

For the purposes of this rule the term:

"Augmentative Communication Device or System" means a specialized type of device or system that transmits or produces messages or symbols in a manner that compensates for the disability of a beneficiary with severe communication impairment.

4.211.2 Covered Services

(a) Covered augmentative communication devices or systems include, but are not limited to, the following:

(1) Non-powered devices,
(2) Battery-powered systems such as specialized typewriters,
(3) Electronic and computerized devices, such as: electrolarynges; portable speech devices; hand-held computers and memo pads; typewriter-style communication aids with an electronic display and/or synthesized speech; electronic memo writers with key or membrane pad; customized assisted keyboards; scanning devices including optical pointer, single switch, mouse, trackball, and/or Morse code access; laptop or micro computers; and computer software, and
(4) Peripheral equipment, such as: eye-gaze systems, mounts, cases, speakers, pointers, switches and switch interfaces that are specific to the use of the device or system, as prescribed.

(b) Other covered services include:

(1) Modification, programming, or adaptation of Medicaid-purchased devices when provided by qualified speech language pathologists, and,
(2) Repair/service on Medicaid-purchased items after the original manufacturer's warranty expires, and when the repair/service is ordered by a qualified provider and provided by a qualified vendor. Rental devices are covered during the repair period.

4.211.3 Qualified Providers and Vendors:

(a) Providers must be licensed, working within the scope of his or her practice and enrolled in Vermont Medicaid.
(b) Vendors must be Medicaid enrolled providers of Durable Medical Equipment.

4.211.4 Conditions for Coverage

(a) Augmentative communication devices and systems must be prescribed by a speech language pathologist, based on a comprehensive evaluation, and endorsed by a physician working within his or her scope of practice. Prescriptions must take into account the beneficiary's current and future needs.

(b) Payment will be made for purchase or rental of augmentative communication devices or systems to

assist a beneficiary in communication when the impairment prevents communication.

(c) An augmentative communication device or system will be approved only if the device or system will be used to meet specific medical objectives or outcomes as specified in the medical necessity documentation. Approved devices or systems shall be used by the beneficiary such that the communication originates from the beneficiary and not from a facilitator or support person.

(d) A trial period is required before authorizing purchase of augmentative communication devices or systems.

(e) Purchase of the trialed device or system will be considered only after the beneficiary has demonstrated the ability to use the device for medically necessary purposes, including but not limited to activities of daily living.

(f) Payment will be made for one primary piece of medical equipment. Duplicate services or equipment in multiple locations will not be covered.

(g) Coverage for replacement equipment will be provided only when the existing device or system no longer effectively addresses the beneficiary's needs.

(h) The Department of Vermont Health Access is the actual owner of all purchased equipment. Such equipment may not be resold. At the discretion of the Commissioner or the Commissioner's designee, augmentative communication devices may be recovered for reuse or recycling when the original beneficiary no longer needs it.

(i) The Department of Vermont Health Access shall be notified when serviceable equipment is no longer needed or appropriate for a beneficiary.

4.211.5 Prior Authorization Requirements

(a) Prior authorization by the Department of Vermont Health Access is required for:

(1) The rental or purchase of all augmentative communication devices or systems, and
(2) Repairs costing more than $500.

(b) The Department of Vermont Health Access reserves the right to request a second opinion or additional evaluations for the purpose of clarifying medical objectives or outcomes.

4.211.6 Non-Covered Services

(a) Environmental control devices, such as switches, control boxes, or battery interrupters, and similar devices that do not primarily address a medical need are not covered.
(b) Training provided by the manufacturer or supplier beyond what is included in the purchase of the device is not covered. However, if additional training is necessary for the beneficiary to set up and use the device, it may be obtained through speech therapy services as covered by Vermont Medicaid.

Prosthetic and Orthotic Devices

4.212 Prosthetic and Orthotic Devices (5/1/2023, GCR 22-099)

4.212.1 Definitions

(a) **"Prosthetic devices"** means replacement, corrective, or supportive devices to: artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body.

This definition is in accordance with the federal definition found at 42 CFR §440.120(c).

(b) **"Orthotic devices"** means devices fashioned to support, correct, or improve the function of a body part.

4.212.2 Covered Services

(a) Prosthetic and orthotic devices are covered when medically necessary.

(b) Vermont Medicaid publishes and maintains a list of pre-approved prosthetic and orthotic devices and any prior authorization requirements. This information is publicly available on the Department of Vermont Health Access website.

4.212.3 Qualified Providers

(a) Prosthetic and orthotic devices must be ordered by a physician or other licensed provider working within the scope of their practice and enrolled with Vermont Medicaid.

4.212.4 Conditions for Coverage

(a) Prosthetic and orthotic devices must be necessary to address a beneficiary's medical condition as ordered by a qualified provider.

(b) The face-to-face requirements in Health Care Administrative Rule 4.209 Durable Medical Equipment apply to prosthetic and orthotic devices that are also subject to the face-to-face requirement under Medicare.

(c) Coverage for Medicaid-approved shoes is limited to two pairs per adult beneficiary per calendar year unless additional pairs are medically necessary.

(d) Custom-made arch supports prescribed by a qualified provider are covered when they meet the definition of an orthotic.

(e) Custom devices are covered only when prefabricated devices cannot meet the medical need.

(f) These conditions for coverage do not apply to prosthetics and orthotics reimbursed as a component of an institutional payment.

4.212.5 Non-Covered Services

(a) Orthotics or prosthetics that primarily serve to address social, recreational, or other factors and do not directly address a medical need.

(b) Duplicate items are not covered.

Audiology Services

4.213 Audiology Services (12/2/2016, GCR 16-076)

4.213.1 Definitions

For the purposes of this rule, the term:

(a) **"Audiology services"** means services related to the diagnosis, screening, prevention and correction of hearing and hearing disorders.

(b) **"Hearing aids"** means wearable instruments or devices to compensate for impaired hearing.

4.213.2 Covered Services

(a) Audiology services approved for coverage are limited to:

(1) Audiologic examinations,
(2) Hearing screening,
(3) Hearing assessments, and
(4) Diagnostic tests for hearing loss.

(b) Covered services for hearing aids include:

(1) Analog or digital hearing aids, plus their repair, replacement, or modification,
(2) Prescriptions for hearing aid batteries, limited to six batteries per month,
(3) Fitting, orientation, and/or checking of hearing aids, and
(4) Ear molds specific to hearing aids.

4.213.3 Conditions for Coverage

(a) Audiology services must be provided by a physician, or licensed audiologist working within the scope of his or her practice and enrolled with Vermont Medicaid.

(b) Hearing aids are covered only for beneficiaries who have at least one of the following conditions or if otherwise medically necessary for children under the age of 21.

(1) Hearing loss in the better ear is greater than 30dB, based on an average taken at 500, 1000, and 2000Hz.
(2) Unilateral hearing loss is greater than 30dB, based on an average taken at 500, 1000, and 2000Hz.
(3) Hearing loss in the better ear is greater than 40dB, based on an average taken at 2000, 3000, and 4000Hz, or word recognition is poorer than 72%.

(c) Hearing aid repairs may not exceed 50% of the replacement cost.

4.213.4 Prior Authorization Requirements

(a) Prior authorization is required for:

(1) More than one analog or digital hearing aid per ear every three years.

(2) More than one hearing aid repair or modification per year, or any repair or modification in excess of $100.

4.213.5 Non-Covered Services

(a) Non-medical items, such as canal aids, maintenance items other than batteries, and fees associated with selection trial periods or loaners, are not covered.

Eyewear and Vision Care Services

4.214 Eyewear and Vision Care Services (12/2/2016, GCR16-076)

4.214.1 Definitions

For the purposes of this rule, the term:

(a) **"Vision care services"** means services, and the prescription of therapeutic drugs, related to the diagnosis and treatment of vision and vision disorders.

(b) **"Eyewear"** means eyeglasses, contact lenses, and other aids to vision, that are prescribed by a licensed physician skilled in diseases of the eye or an optometrist.

(c) **"Eyeglasses"** means lenses and/or frames.

4.214.2 Conditions for Coverage

(a) Eligibility for Eyewear and Vision Care Services:

(1) Vision care services are provided to beneficiaries of any age.
(2) Coverage of eyewear is limited to beneficiaries under the age of 21.

(b) Qualified Providers of Eyewear and Vision Care Services:

(1) Vision care services must be provided by a licensed physician skilled in diseases of the eye or an optometrist working within the scope of his or her practice, and enrolled in Vermont Medicaid.
(2) An optician, optometrist, or ophthalmologist may provide eyeglass-dispensing services.
(3) Eyeglasses and their repairs or replacements are provided through the Department of Vermont Health Access' contracted vendor.

4.214.3 Covered Services

(a) Vision care services approved for coverage include:

(1) Refraction and eye exams when provided by an ophthalmologist or optometrist enrolled in Vermont Medicaid.
(2) Routine eye exams with the following limitations:
(A) One comprehensive eye exam and one intermediate eye exam within a two-year period, or
(B) Two intermediate eye exams within a two-year period.
(3) Diagnostic testing.
(4) Non-eyewear aids to vision, such as closed circuit television, when the beneficiary is legally blind and when providing the aid to vision will foster independence by improving at least one activity of daily living or instrumental activity of daily living.

(b) Eyeglasses, with the following limitations, are covered as follows:

(1) For beneficiaries under the age of six:

(A) One pair of eyeglass frames per year,

(B) One new lens per eye per year,
(C) One fitting per year.

(2) For beneficiaries ages six through 20:

(A) One pair of eyeglass frames per two years, and
(B) One new lens per eye per two years, and
(C) One fitting per two years.

(c) Earlier replacement of eyeglasses is limited to the following circumstances:

(1) Eyeglasses have been lost.
(2) Eyeglasses have been broken beyond repair.
(3) Lenses are scratched to the extent that visual acuity is compromised.
(4) The beneficiary's vision has changed by at least one-half diopter in a single lens.
(5) Frame size changed due to significant inter-pupillary distance change.

4.214.4 Prior Authorization Requirements

Prior authorization is required for:

(a) Contact lenses,
(b) Special lenses,
(c) Photo-sensitive lenses,
(d) Other aids to vision including those non-eyewear aids allowed under 4.214.3(a)(4),
(e) Routine eye exams in excess of the number allowed, and
(f) Frames and/or lenses in excess of the number allowed for any reason other than the conditions in 4.214.3(c).

4.220 Chiropractic Services (5/26/17, GCR 16-120)

4.220.1 Definitions

For the purposes of this rule, the term:

"Chiropractic services" means treatment by methods of manual manipulation of the spine in accordance to 42 CFR § 440.60.

4.220.2 Covered Services

Covered chiropractic services are limited to the treatment to correct a subluxation of the spine.

4.220.3 Qualified Providers

Chiropractic services must be provided by a licensed chiropractor working within the scope of his or her practice and enrolled in Vermont Medicaid.

4.220.4 Conditions for Coverage

The existence of the subluxation shall be demonstrated by means of:

(a) An x-ray supplied by the beneficiary taken by a provider other than a chiropractor no earlier than three months prior to initiation of care, or
(b) A physical examination conducted by the provider performing the correction of the subluxation.

4.220.5 Prior Authorization and Documentation Requirements

(a) Chiropractic services require prior authorization from the Department of Vermont Health Access for the following:

(1) Beneficiaries under the age of 12, or
(2) Beneficiaries age 12 and older who have exceeded 10 treatments for correction of subluxation in the calendar year.

(b) Chiropractic services for children age five and under require prior authorization and require documentation from the primary care physician demonstrating medical necessity of chiropractic treatment.

4.220.6 Non-Covered Services

Medicaid does not cover an x-ray ordered solely for the purpose of demonstrating a subluxation of the spine. Any charges incurred for the chiropractic x-ray must be borne by the beneficiary.

Podiatry Services

4.221 Podiatry Services (5/1/2023, GCR 22-099)

4.221.1 Definitions

(a) **"Podiatry services"** means the diagnosis and treatment of ailments of the foot, ankle, and lower extremity.

4.221.2 Covered Services

(a) Vermont Medicaid covers medically necessary podiatry services.

(b) Routine foot care, including the cutting or removing of corns and calluses, and trimming, cutting, clipping, or debriding of toenails, is covered when medically necessary for beneficiaries who have a medical condition, including diabetes or a peripheral vascular disease, that affects the lower extremities.

4.221.3 Qualified Providers

(a) Podiatry services are covered when performed by a licensed podiatrist, or other licensed providers, working within their scope of practice.

4.221.4 Non-Covered Services

(a) Hygienic care including cleaning or soaking of feet is not covered.

(b) Services performed in the absence of a medical condition or injury involving the foot, ankle, or lower extremity are not covered.

(c) Routine foot care services are not covered, except as provided at HCAR 4.221.2(b), even if the individual is unable to perform these services for themself.

Whole Blood

4.222 Whole Blood (07/30/2016, GCR 16-029)

4.222.1 Conditions for Coverage

(a) Whole blood is provided without cost through the Red Cross Blood Program.

(b) Costs for storing, processing, administering, or transfusing blood products are covered as an inpatient hospital, outpatient or physician's service.

Abortion

4.223 Abortion (02/22/2018), GCR 17-073)

4.223.1 Qualified Providers

Abortions must be provided by a physician, physician assistant, advanced practice nurse practitioner, or certified nurse midwife working within the scope of his or her practice and enrolled in Vermont Medicaid.

4.223.2 Conditions for Coverage

(a) A qualified provider must sign and submit the appropriate Department of Vermont Health Access Abortion Certification form prior to reimbursement.

(b) Federal reimbursement is limited to abortions certified by a doctor of medicine or osteopathy that:
(1) The life of the mother would be endangered if the fetus were carried to term, or
(2) The pregnancy is the result of an act of rape or incest.

Sterilizations and Related Procedures

4.224 Sterilizations and Related Procedures (8/6/2016, GCR 16-029)

4.224.1 Conditions for Coverage

(a) Sterilization of either a male or female beneficiary is covered only when all the following conditions are met:

(1) The beneficiary has voluntarily given informed consent and has so certified by signing a consent for sterilization form in accordance with 42 CFR Part 441, Appendix to Subpart F.

(2) The beneficiary is mentally competent.

(3) The beneficiary is at least 21 years old at the time consent is obtained.

(4) At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery.

(A) In the case of premature delivery or emergency abdominal surgery:

(i) At least 72 hours must have passed between the informed consent and the operation; and
(ii) In the case of premature delivery the consent for sterilization form must have been signed at least 30 days before the expected delivery date.

(b) Hysterectomy is covered only when the following conditions are met:

(1) Oral or written consent is provided and documentation shows written acknowledgement of the receipt of the information before the hysterectomy, or

(2) In the case that oral or written consent is not given, a physician certifies that:

(A) The individual was already sterile before the hysterectomy, or
(B) A life threatening situation existed making prior acknowledgement not possible, and the nature of the emergency.

4.224.2 Non-Covered Services

(a) Operations or procedures performed for the purpose of reversing or attempting to reverse the effects of any sterilization procedure are not covered.

(b) A hysterectomy is not covered if:

(1) It was performed solely for the purpose of rendering an individual incapable of reproducing; or

(2) There was more than one purpose to the procedure, and it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

4.225 Non-Emergency Medical Transportation (04/01/2021, GCR 20-097)

4.225.1 Definitions

The following definitions shall apply for use in Rule 4.225:

(a) **"Broker"** means an entity that, pursuant to a contract with Vermont Medicaid, procures and manages non-emergency transportation for eligible Medicaid beneficiaries.

(b) **"Related travel expenses"** means the cost of meals and lodging en route to and from medical care at per diem rates established by Vermont Medicaid.

4.225.2 Covered Services

(a) Transportation to and from necessary, non-emergency medical services is covered and available to eligible Medicaid beneficiaries on a statewide basis. Transportation includes expenses for non-emergency medical transportation and other related travel expenses determined to be necessary by Vermont Medicaid to secure medically necessary services.

(b) Medicaid will cover transportation and related travel expenses for one adult attendant while the need exists if the beneficiary:
   (1) Is a minor under 18 years of age, or
   (2) Has documented medical need from their treating provider for an attendant to accompany them to and from medical care.

(c) Ambulance services, including for non-emergency care, are described in Rule 4.226 Ambulance Services.

4.225.3 Qualified Providers

Only transportation providers subcontracted with the Broker and enrolled in Vermont Medicaid are eligible to receive Medicaid payment to provide transportation under this rule.

4.225.4 Conditions for Coverage

The following limitations on coverage shall apply:

(a) Transportation is not otherwise available to the Medicaid beneficiary.

(b) Transportation is to and from medically necessary services.

(c) Transportation is to a provider located within a 30-mile radius of the beneficiary's home. If there is no qualified provider within this 30-mile radius, Vermont Medicaid will transport to the nearest available qualified provider.

(d) Payment is made for the least expensive mode of transportation available and appropriate to meet the medical needs of the beneficiary.

4.225.5 Prior Authorization Requirements

Prior authorization is required for coverage of transportation.

4.225.6 Non-Covered Services

Transportation to any activity, program, or service that is not payable by Vermont Medicaid or is not directly provided to a Medicaid beneficiary by a Medicaid-enrolled provider is not covered.

Ambulance Services

4.226 Ambulance Services (04/01/2021, GCR 20-097)

4.226.1 Definitions

The following definition shall apply for use in Rule 4.226:

(a) **"Ambulance"** means any vehicle, whether for use by air, ground, or water, that is primarily designed, used, or intended for use in transporting ill or injured persons.

4.226.2 Covered Services

Transportation via ambulance is covered for the following:

(a) Emergency services, as described in Rule 4.102, and

(b) Non-emergency services when the conditions for coverage under this rule are met.

4.226.3 Eligibility for Care

Vermont Medicaid covers medically necessary ambulance services for Medicaid beneficiaries for whom other methods of transportation would be medically contra-indicated. No payment will be made when some means of transportation other than an ambulance could have been used without endangering the individual's health.

4.226.4 Qualified Providers

Ambulance providers currently enrolled with Vermont Medicaid.

4.226.5 Conditions for Coverage

In order for ambulance services provided to eligible Medicaid beneficiaries to be covered, the following conditions must be met:

(a) Any non-emergent ambulance service must be ordered by a physician or certified as to necessity by a physician at the receiving facility. If an ambulance provider is unable to obtain a signed physician certification statement from the beneficiary's attending physician, a signed certification statement must be obtained from either the physician assistant, nurse practitioner, clinical nurse specialist, licensed social worker, case manager, or discharge planner.

(b) Ambulance transportation must be to or from a Medicaid covered service. Ambulance transportation will not be reimbursed if the covered service in question requires prior authorization and such authorization was not obtained from Vermont Medicaid.

4.226.7 Non-Covered Services

Ambulance services from hospital-to-facility for the provision of outpatient services that are not available at the originating hospital must be paid for by the originating hospital, and should not be separately billed to Vermont Medicaid.

4.227 Hospice Services (07/30/2016, GCR 16-029)

4.227.1 Conditions for Coverage

4.227.1.1 Eligibility

For a beneficiary to receive hospice coverage, all of the following conditions must be met:

(a) A physician must certify that the beneficiary is within the last six months of life; and

(b) The beneficiary requesting hospice coverage has signed an election of hospice care.

(i) For beneficiaries age 19 and over, the election of hospice care waives all other Medicaid coverage except the services of a designated family physician, ambulance service, and services unrelated to the terminal illness.

(ii) Children under the age of 19 may receive hospice services concurrently with curative treatment.

4.227.1.2 Conditions

(a) Hospice services to terminally ill recipients are covered in accordance with 42 U.S.C. § 1396d(o).

(b) Hospice services must be rendered by a Medicare-certified hospice provider and in accordance with Medicare conditions of participation.

4.227.1.3 Reimbursement

(a) Payment to enrolled hospice providers will be made at the daily rates set by Medicare for each provider. Rates of payment and total reimbursement for hospice care will be made in accordance with Medicare reimbursement and audit principles.

(b) Medicaid will make no payment to the hospice provider selected by the Medicaid beneficiary for any services or supplies other than the hospice service.

(c) The hospice provider may not charge any amount to or collect any amount from the beneficiary or the beneficiary's family for a covered hospice service during the period of hospice coverage.

(d) Other than the provisions in section 4.227.1.1(b)(i) and(ii), no institutional provider (skilled nursing facility, hospital or intermediate care facility) will be paid for other services while a beneficiary is receiving hospice services in its facility, including room and board.

Transplantation Services

4.228 Transplantation Services (5/1/2023, GCR 22-099)

4.228.1 Definitions

For the purposes of this rule, the term:

"Transplantation services" means a medical procedure performed to replace a diseased or damaged body part with a healthy one.

4.228.2 Covered Services

Vermont Medicaid covers medically necessary transplantation services for the beneficiary including harvesting, preservation, and transportation of cadaver organs. Vermont Medicaid also covers, under the Medicaid of the person receiving the transplantation, medically necessary transplantation services for live donors, including post transplantation services and transportation.

4.228.3 Qualified Providers

Providers must be working within the scope of their practice and enrolled in Vermont Medicaid. Providers must also be certified by the American Society of Transplant Surgeons (ASTS) and maintain their membership in good standing and experienced in post-operative care and management of an immunosuppressive regimen.

4.228.4 Qualified Facilities

The transplant facility must meet the following criteria:

(a) Be fully accredited as a transplant center by applicable state and federal agencies.

(b) Be in compliance with all applicable state and federal laws which apply to organ acquisition and transplantation including equal access and non-discrimination laws.

(c) Have an interdisciplinary team to determine the suitability of candidates for transplantation on an equitable basis.

(d) At the time Medicaid coverage is requested, the center must provide current documentation that it provides high quality care relative to other transplant centers.

(e) Provides all medically necessary services required including management of complications of the transplantation and late infection and rejection episodes. Failure of the transplant is considered a complication and re-transplantation must be available at the center.

4.228.5 Conditions for Coverage

The Medicaid beneficiary must meet the following conditions:

(a) The Medicaid beneficiary has a condition for which transplantation is the appropriate treatment.

(b) All other medically feasible forms of medical or surgical treatment have been considered, and the most effective and appropriate medically indicated alternative for the beneficiary is transplantation services.

(c) The Medicaid beneficiary meets all medical criteria for the proposed type of transplantation based upon the prevailing standards and current practices. These would include, but are not limited to:

(1) Test lab results within identified limits to assure successful transplantation and recovery.

(2) Diagnostic evaluations of the beneficiary's medical and mental health that indicate there will be no significant adverse effect upon the outcome of the transplantation.

(3) Assessment of other relevant factors that might affect the clinical outcome or adherence to an immunosuppressive regimen and rehabilitation program following the transplant.

(4) The beneficiary or an individual authorized to make health care decisions on the beneficiary's behalf has been fully informed of the risks and benefits of the proposed transplant including the risks of complications, continuing care requirements, and the expected quality of life after the procedure.

4.228.5 Prior Authorization

The Vermont Medicaid fee schedule contains a detailed list of covered services and indicates which services require prior authorization. The fee schedule can be found on the Department of Vermont Health Access website.

4.228.6 Non-Covered Services

Transplantation services are not covered if the procedure is experimental or investigational.

Applied Behavior Analysis Services

4.229 Applied Behavior Analysis Services (8/1/2021, GCR 21-016)

4.229.1 Definitions

For the purposes of this rule, the term:

(a) **"Applied Behavior Analysis (ABA)"** means the design, implementation, and evaluation of the instructional and environmental modifications by a behavior analyst to provide socially significant improvements in human behavior.

(b) **"Board Certified Behavior Analyst (BCBA)"** means an independent practitioner who provides ABA services, holds a master's degree, and is certified through the National Behavior Analyst Certification Board (BACB). BCBAs also supervise the work of Board Certified Assistant Behavior Analysts and Behavior Technicians.

(c) **"Board Certified Assistant Behavior Analyst (BCaBA)"** means an ABA provider who holds a minimum of a bachelor's degree, is certified through the BACB, and is directly supervised by a BCBA. BCaBAs may supervise the work of Behavior Technicians.

(d) **"Behavior Technician (BT)",** including **"Registered Behavior Technician (RBT)"** means an ABA provider who holds a bachelor's degree, or is pursuing a bachelor's degree, and practices under close, ongoing supervision of a BCBA or BCaBA supervisor. Relevant experience may be exchanged for a degree.

4.229.2 Covered Services

Medically necessary ABA services include:

(a) Functional Assessment and Analysis
(b) Treatment plan development
(c) Direct treatment
(d) Program supervision
(e) Parent/caregiver training
(f) Team conferences

4.229.3 Eligibility for Care

For a beneficiary to receive ABA services, they must:

(a) Be actively enrolled in Medicaid at the time of the service,
(b) Be under the age of 21,
(c) Have a Diagnostic and Statistical Manual of Mental Disorders (latest edition) diagnosis of Autism Spectrum Disorder, early childhood developmental disorder, or any successor diagnosis,
(d) Have a prescription for ABA from a:

(1) Board certified or board eligible psychiatrist,
(2) Doctorate-level licensed psychologist,

(3) Board certified or board eligible pediatrician,
(4) Board certified or board eligible neurologist, or
(5) Developmental-behavioral or neurodevelopmental disabilities pediatrician, and

(e) Be medically stable and not require 24-hour medical/nursing monitoring or procedures provided in a hospital level of care on an ongoing basis.

4.229.4 Qualified Providers

BCBAs and BCaBAs providing ABA services must be licensed in Vermont, working within the scope of their practice, and enrolled in Vermont Medicaid.

4.229.5 Prior Authorization Requirements

The Vermont Medicaid Fee Schedule contains a detailed list of covered services and indicates which services require prior authorization. The Fee Schedule can be found on the Department of Vermont Health Access website.

4.229.6 Non-Covered Services

Vermont Medicaid will not authorize ABA services for any of the following:

(a) School-based ABA services authorized under the Individuals with Disabilities Education Act (IDEA) and reimbursed by the Agency of Education,
(b) Respite care,
(c) Orientation and mobility,
(d) Psychiatric hospitalization, or
(e) Medicaid beneficiaries in long term out-of-home placement/care outside a community setting.

Home Health Services

4.231 Home Health Services (01/07/2019, GCR 18-037)

4.231.1 Definitions

(a) **"Home health agency"** means a public or private agency or organization, or part of either, that meets the requirements for participation in Medicare, and complies with the Vermont regulations for the designation and operation of home health agencies.

(b) **"Home health services"**, for the purposes of this rule, means the services described at 4.231.2(a), when provided according to a plan of care described at 4.231.4(b), by a home health agency on a part-time or intermittent basis.

4.231.2 Covered Services

(a) Home health services are covered when medically necessary. Services that are covered include:

(1) Nursing services,
(2) Home health aide services,
(3) Medical supplies, and durable medical equipment,
(4) Physical therapy, occupational therapy, or speech language pathology services, and
(5) Medical social work services.

4.231.3 Qualified Providers

(a) Home health agency providers must be Medicare certified and enrolled in Vermont Medicaid.

(b) Home health services must be ordered by a physician who is enrolled in Vermont Medicaid and working within the scope of his or her practice.

(c) The following non-physician practitioners (NPP) may perform the face-to-face encounter as required in 4.231.4(c) of this rule:

(1) A nurse practitioner, clinical nurse specialist, or certified nurse midwife working in collaboration with the ordering physician, or
(2) A physician assistant under the supervision of the ordering physician.

(d) For beneficiaries admitted to home health services immediately after an acute or post-acute stay, the attending acute or post-acute physician may perform the face-to-face encounter.

4.231.4 Conditions for Coverage

(a) General Conditions

(1) Home health services are not limited to services furnished to beneficiaries who are homebound.

(2) Coverage of home health services are not contingent upon the beneficiary needing nursing or therapy services.

(b) Plan of Care Requirements

(1) Items and services shall be ordered under a written plan of care approved by the ordering physician. The plan of care shall include the following:

(A) The diagnosis, and a description of the patient's functional limitation resulting from illness, injury, or condition,
(B) The type and frequency of medically necessary home health services,
(C) Long term prognosis as a result of the services,
(D) The ordering physician's certification that the services and items specified in the plan of care can be provided through a home health agency.

(2) Initial orders for home health services shall include documentation that the face-to-face visit occurred, as required in 4.231.4(c).

(3) Any changes in a plan of care shall be signed by the physician. A nurse or qualified therapist responsible for furnishing or supervising the ordered services may accept and document the physician's oral orders. All oral orders must be authenticated and dated by the physician.

(4) The plan of care shall be reviewed by the physician, in consultation with home health agency personnel, at least every 60 days.

(c) Face-to-Face Visit Requirements

(1) For the initiation of home health services, a qualified provider must conduct a face-to-face encounter with the beneficiary no more than 90 days prior to, or 30 days after, the start of service.

(2) The face-to-face encounter must be related to the primary reason the beneficiary requires home health services.

(3) The face-to-face encounter may be conducted in person or through telemedicine.

(4) The physician ordering home health services must document:

(A) That the face-to-face encounter is related to the primary reason the beneficiary requires home health services,
(B) That the face-to-face encounter occurred within the required timeframe,
(C) The practitioner who conducted the encounter, and
(D) The date of the encounter.

(5) The NPP performing the face-to-face encounter must communicate the clinical findings of that face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.

(d) Location Where Service is Provided

(1) Home health services may be received in any setting in which normal life activities take place other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (unless such services are not otherwise required to be provided by the facility), or any setting in which payment could be made under Medicaid for inpatient services that include room and board.

(2) An initial assessment visit to determine the need for home health services may be performed by a registered nurse or appropriate therapist in a hospital, nursing home, or community setting.

(e) Requirements Specific to Home Health Aide Services

(1) Services of a home health aide are covered in accordance with a written plan of care ordered by a physician and supervised by a registered nurse, physical therapist, occupational therapist, or speech language pathologist.

(2) The home health aide may provide medical assistance, personal care, assistance in activities of daily living, assistance with a home exercise program, and training the beneficiary in self-help skills.

(3) The home health aide may perform household chores that are incidental to the visit, and specific to the beneficiary.

(4) Supervisory visits by a registered nurse or appropriate therapist must be performed at least every 60 days.

(f) Requirements Specific to Medical Supplies

(1) Medical supplies are covered when they are needed to treat the beneficiary in accordance with the physician-ordered plan of care.

(2) Routine medical supplies used during the usual course of most home visits are included in the home visit charges and not reimbursed separately.

(3) The coverage limitations specific to medical supplies described elsewhere in rule apply to medical supplies provided by a home health agency.

(g) Requirements Specific to Durable Medical Equipment

(1) The rental of certain durable medical equipment (DME) owned by the home health agency and required in the beneficiary's plan of care is covered when conditions of coverage for DME are met.

(2) The DME coverage limitations described elsewhere in rule apply to DME provided by a home health agency.

(h) Requirements Specific to Therapy Services

(1) Physical therapy, occupational therapy, and speech language pathology services are covered for up to four months per medical condition, based on a physician's order. Provision of these services beyond this initial four-month period requires prior

authorization. Therapy services must be:

(A) Directly related to an active treatment regimen designed or approved by the physician, and require a level of complexity such that the judgment, knowledge, and skills of a qualified therapist are required, and
(B) Reasonable and necessary under accepted standards of medical practice for the treatment of the patient's condition.

(2) The physical therapy, occupational therapy, and speech language pathology services described elsewhere in rule apply to therapy services provided by a home health agency.

Medically Complex Nursing Services

4.232 Medically Complex Nursing Services (01/01/2020, GCR 19-058)

4.232.1 Definitions

For the purpose of this rule the term:

(a) **"Medically Complex Nursing Services"** means medically necessary nursing care for individuals who are technology dependent or individuals living with complex medical needs requiring specialized nursing skills or equipment, as part of Vermont Medicaid's High Tech Nursing Program.

(b) **"Needs Assessment"** means a standardized assessment tool, established by the State, to assist in the determination of medical necessity and nursing service allocations.

(c) **"State Authorized Clinical Provider"** means a licensed or certified healthcare provider authorized to administer the needs assessment.

(d) **"Technology Dependent"** means the use of medical devices without which adverse health consequences or hospitalization would likely follow.

4.232.2 Covered Services

(a) Medically complex nursing services include:

(1) Daily continuous or intermittent mechanical ventilation via tracheotomy,
(2) Tracheotomy and/or unstable airway requiring nursing assessment and intervention,
(3) Specialized nursing care due to a documented medical condition or disability which requires ongoing skilled observation, monitoring, and judgement to maintain or improve the health status of a medically fragile or medically complex condition,
(4) Nursing care plan management and oversight, as appropriate and permitted within a nurse's scope of practice

4.232.3 Eligibility for Care

(a) To receive services the following requirements must be met:

(1) Services are under the direction of a physician in a treating relationship with the beneficiary.
(2) The individual undergoes a needs assessment by a State-authorized clinical provider to determine eligibility for services.
(3) The needs assessment tool documents the need for medically complex nursing services and the number of service units which exceed the frequency, duration and complexity of care provided through home health nursing services.
(4) Subsequent assessments occur at least annually or at the request of the State or the beneficiary when necessitated by a change in the medical needs of the beneficiary.
(5) Use of a medical device alone does not qualify a beneficiary for medically complex nursing services.

4.232.4 Qualified Providers

Medically Complex Nursing Services

(a) Medically complex nursing services will be provided by a Registered Nurse or a Licensed Practical Nurse who is employed by a Medicaid enrolled home health agency, or directly enrolled with Vermont Medicaid.

4.232.5 Conditions for Coverage

(a) Services must be individualized, person-centered, and provided exclusively to the authorized individual in the home or a community setting where normal life activities take place outside of the home.

(b) Services are prior authorized annually. Payment for services will not exceed the units authorized. Any unused service units will not be carried forward from prior authorization period to prior authorization period or used for other services.

4.232.6 Non-Covered Services

(a) Care or services not considered medically complex nursing include: custodial care, respite care, observational care for emotional and behavioral conditions, treatment for eating disorders, or treatment for medical conditions that do not require specialized nursing care.

4.233 Children's Personal Care Services (04/1/2024, GCR # 23-131)

4.233.1 Definitions

For the purposes of this rule the term:

(a) **"Activities of Daily Living"** (ADL) means activities including dressing, bathing, grooming, eating, transferring, mobility, and toileting.

(b) **"Children's Personal Care Services"** (CPCS) means medically necessary services related to ADLs and IADLs that are furnished to a beneficiary, as part of Vermont Medicaid's Children's Personal Care Services Program.

(c) **"Electronic Visit Verification"** (EVV) means a telephone and computer-based system that records information about the services provided.

(d) **"Employer"** means the individual or entity who is responsible for the hiring of and ensuring payment to the personal care attendant when services are self-directed.

(e) **"Functional Ability Screening Tool"** means a State adopted standardized assessment tool to assist in the determination of medical necessity for children's personal care services.

(f) **"Instrumental Activities of Daily Living"** (IADL) means activities including personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.

(g) **"Legally Responsible Individual"** means the beneficiary's biological parent, stepparent, adoptive parent, legal guardian, spouse, or civil union partner.

(h) **"Personal Care Attendant"** means an individual at least 18 years of age, who has successfully passed required background checks, and who is qualified to provide children's personal care services. A personal care attendant must not be a legally responsible individual.

(i) **"Self-Directed"** means children's personal care services that are managed directly by the beneficiary, family member, guardian, or guardian's designee.

(j) **"Variance"** means a decision by the Children's Personal Care Services Program to waive certain restrictions, including hiring a personal care attendant less than 18 years old, waiving certain background check findings, and paying greater than the maximum wage established.

4.233.2 Covered Services

(a) Covered children's personal care services must be medically necessary and may include:
(1) Assistance with bathing, dressing, grooming, bladder, or bowel requirements,
(2) Assistance with eating, drinking, feeding, or dietary activities,
(3) Assistance in monitoring vital signs,
(4) Routine skin care,

(5) Assistance with positioning, lifting, transferring, ambulation, and exercise,
(6) Set-up, supervision, cueing, prompting, and guiding, when provided as part of the assistance with ADLs,
(7) Assistance with age appropriate IADLs that are essential to the beneficiary's care at home,
(8) Assistance with taking medications,
(9) Assistance with the use of durable medical equipment including adaptive or assistive devices, and
(10) Accompanying the recipient to clinics, physician office visits, or other trips which are medically necessary.

(b) Services must be individualized and be provided exclusively to the beneficiary.

(c) Children's personal care services can only be provided to one recipient at a time.

4.233.3 Eligibility for Care

(a) To be eligible for children's personal care services a beneficiary must:
(1) Be under the age of 21,
(2) Have a medical condition, disability, or cognitive impairment as documented by a physician, psychologist, psychiatrist, physician's assistant, advanced practice registered nurse, licensed mental health clinician, or other licensed clinician working within their scope of practice.
(3) Qualify for medically necessary children's personal care services based on functional limitations in age-appropriate ability to perform ADLs, as prior authorized by the Children's Personal Care Services Program.
(4) Not be an inpatient or resident of a hospital, nursing facility, intermediate care facility for people with developmental disabilities, or institution for mental disease.

4.233.4 Prior Authorization

(a) Services must be prior authorized by the Children's Personal Care Services Program.

(b) The following is used to authorize the hours of children's personal care services:
(1) A Functional Ability Screening Tool assessment of age-appropriate ability to perform ADLs completed by a state sanctioned assessor, and
(2) Individualized clinical review of relevant supporting materials, description of direct observation, diagnosis verification, and a care plan. Clinical review is completed by a licensed clinician employed by the Agency of Human Services.

(c) Re-determination authorizing eligibility is required for services in accordance with the following:
(1) Every twelve months from the initial authorization date through age 5,
(2) Changing to every 3 years, from the last authorization date, if the beneficiary has two consecutive years of the same evaluation outcome, or
(3) When there is a change in the beneficiary's ability to perform age-appropriate ADLs and IADLs.

4.233.5 Qualified Providers

(a) The following individuals are eligible to deliver children's personal care services through the Children's Personal Care Services Program:
(1) Personal care attendants, and
(2) Legally responsible individuals.

4.233.6 Conditions for Coverage

(a) The coverage and conditions of this rule apply to services that are delivered outside of any personal care services authorized as a component of the Medicaid School Based Health Services Program in accordance with an Individual Education Plan (IEP).

(b) A personal care attendant is eligible to deliver services when employed by a home health agency, other agency designated to furnish children's personal care services, or employed as a self-directed personal care attendant.

(c) When children's personal care services are self-directed the following conditions apply:
(1) The employer must use the state sanctioned fiscal employer agent for payroll and administrative services.
(2) The employer may pay personal care attendants a flexible wage. The flexible wage must not be lower than the minimum wage, as established by the applicable Collective Bargaining Agreement between the State of Vermont and Vermont Homecare United, American Federation of State County and Municipal Employees Council 93 – Local 4802, or higher than the maximum wage published by the Children's Personal Care Program.
(3) A variance to pay greater than the maximum wage may be requested by an employer to the Children's Personal Care Services Program. Variance requests are determined by Children's Personal Care Services Program. Services must be provided in the most cost-effective manner possible. Different rates of pay may be paid to different personal care attendants providing services to the same beneficiary. The rate may be based on level of experience, specialized skills, shifts worked, and hiring needs determined by the employer.
(4) All services must be paid within the awarded amount. The awarded amount is based on the current Medicaid rate on file for the authorized hours of service. The current Medicaid rate is published on the Vermont Department of Health's website. Payments made above the Medicaid rate on file will result in the beneficiary receiving fewer authorized hours of service.
(5) The employer is responsible for paying the appropriate payroll taxes for a personal care attendant out of the awarded amount.

(d) Legally responsible individuals may be compensated for delivering children's personal care services under the following conditions:
(1) The individual must provide an attestation to the Children's Personal Care Program that children's personal care services are unavailable from a personal care attendant due to significant and recurring barriers,
(2) The individual must provide an attestation to the Children's Personal Care Program that they are able to deliver the medically necessary children's personal care services to the beneficiary, and

(3) The individual must agree to use the state sanctioned fiscal employer agent for billing and administrative services.
(4) Legally responsible individuals must be paid the current Medicaid rate on file, and not a flexible rate.
(5) The individual must not be listed on the U.S. Health and Human Services Office of Inspector General, List of Excluded Individuals/Entities.

(e) Personal care providers must use a Vermont Medicaid authorized Electronic Visit Verification system to collect the following information every time services are provided:
(1) Type of service performed,
(2) Date of service delivery,
(3) Start time and end time of service delivery,
(4) Location of service delivery,
(5) Name of the service provider, and
(6) Name of the beneficiary.

(f) Personal care providers are not required to use the EVV system under the following conditions:
(1) When services are provided entirely outside of the beneficiary's home, or
(2) When the personal care provider lives in the home with the beneficiary.

Gender Affirmation Surgery for the Treatment of Gender Dysphoria

4.238 Gender Affirmation Surgery for the Treatment of Gender Dysphoria (11/1/2019, GCR 19-021)

4.238.1 Definitions

For the purposes of this rule, the term:

(a) **"Gender Affirmation Surgery"** means the surgical procedures by which the physical appearance and function of a person's primary and/or secondary sex characteristics are modified to establish greater congruence with their gender identity.

(b) **"Gender Dysphoria"** means a clinical diagnosis as provided in the *Diagnostic and Statistical Manual of Mental Disorders (Latest Edition)* definition of Gender Dysphoria, or any successor diagnosis.

(c) **"Gender Identity"** means an individual's intrinsic sense of being a man, woman, neither, both, or an alternative gender, or characteristics intrinsically related to an individual's gender, regardless of the individual's sex assigned at birth.

(d) **"Gender Role"** means the lived role or expression characterized by a person's personality, appearance, and behavior that in a given culture and historical period is designated as masculine, feminine, or an alternative gender role.

(e) **"Qualified Mental Health Professional"** means a licensed practitioner, practicing within their scope, who possesses the following minimum credentials:
   (1) A masters level degree or a more advanced degree in a clinical behavioral science field, granted by an institution accredited by the appropriate national or regional accrediting board, and
   (2) Ability to recognize and diagnose co-occurring mental health concerns and to distinguish these from gender dysphoria.

4.238.2 Covered Services

Coverage is available, as specified below, for gender affirmation surgeries for the treatment of gender dysphoria. Coverage includes only the specific surgeries stated as covered below. Prior authorization is required for all gender affirmation surgeries for the treatment of gender dysphoria.

Covered surgeries are limited to the following:
(a) Orchiectomy,
(b) Penectomy,
(c) Vaginoplasty (including hair removal when required),
(d) Clitoroplasty,
(e) Labiaplasty,
(f) Hysterectomy,

(g) Salpingectomy,
(h) Oophorectomy,
(i) Salpingo-oophorectomy,
(j) Vaginectomy,
(k) Prostatectomy,
(l) Metoidioplasty,
(m) Scrotoplasty,
(n) Urethroplasty,
(o) Phalloplasty (including hair removal when required),
(p) Testicular prosthesis,
(q) Breast augmentation mammoplasty, and
(r) Mastectomy.

4.238.3 Eligibility for Care

Vermont Medicaid beneficiaries who are diagnosed with and receiving treatment for gender dysphoria, who satisfy all conditions set forth in this rule, and for whom the service(s) for which prior authorization is sought is both medically necessary and developmentally appropriate are eligible for coverage of the services governed by this rule.

4.238.4 Qualified Providers

Gender affirmation surgery is only covered when the surgeon performing the surgery is a board-certified urologist, gynecologist, or plastic or general surgeon, as appropriate to the requested service. The surgeon must have demonstrated specialized competence in genital and/or breast reconstruction. Any service covered by Medicaid under this rule must be provided by a licensed and enrolled Medicaid provider working within their scope of practice.

4.238.5 Conditions for Coverage

(a) For a beneficiary to receive coverage for gender affirmation surgery, the following conditions must be met:

(1) Written clinical evaluation that may be in the form of a letter documenting eligibility and medical necessity from qualified mental health professional(s):
(A) For breast surgery, a written clinical evaluation must be submitted by one qualified mental health professional.
(B) For genital surgery, two written clinical evaluations must be submitted by two separate qualified mental health professionals. The first referral should be from the individual's treating qualified mental health professional, and the second referral may be from a person who has only had an evaluative role with the individual.
(C) A written clinical evaluation by a qualified mental health professional will include at a minimum:
(i) A diagnosis of persistent gender dysphoria, with demonstrated participation in a treatment plan in consolidating gender identity,

(ii) Diagnosis and treatment of any co-morbid conditions,
(iii) Counseling of treatment options and implications,
(iv) Pyschotherapy, if indicated,
(v) Affirmation that the beneficiary has been assessed face-to-face by the qualified mental health professional,
(vi) Formal recommendation of readiness for surgical treatment, documented in a letter that includes:
(1) Documentation of all diagnoses,
(2) Duration of professional relationship and type of therapy,
(3) Rationale for surgery, and
(4) Follow-up treatment plan.

(2) Documentation of medical necessity from a medical provider working in conjunction with the qualified mental health professional(s).

(3) Completion of at least 12 months of living in a gender role that is congruent with their gender identity.

(4) Documentation of hormonal therapy, as appropriate to the beneficiary's gender goals, unless such therapy is medically contraindicated. Specific hormonal therapy pre-requisites are as follows:
(A) At least 12 consecutive months for metoidioplasty, phalloplasty, vaginoplasty, and breast augmentation mammoplasty.
(B) There is no hormonal therapy pre-requisite for coverage of mastectomy.

(5) Documented informed consent, including knowledge of risks, hospitalizations, post-surgical rehabilitation, and compliance of treatment. For minors under 18 years of age, documented informed consent of a parent(s), legal custodian, or guardian is also required unless the minor is emancipated by court order.

(b) Breast augmentation mammoplasty may be considered medically necessary when clinical criteria is met and when 12 months of continuous hormone therapy has not resulted in breast development that, in the opinion of the qualified mental health professional, is sufficient to treat the beneficiary's symptoms of gender dysphoria.

(c) When treatment for gender dysphoria includes a hysterectomy, coverage is contingent on meeting conditions described in HCAR 4.224.1(b).

4.238.6 Prior Authorization Requirements

Prior authorization is required for all gender affirmation surgeries for the treatment of gender dysphoria. Every request for prior authorization under this rule will be reviewed on an individual basis.

4.238.7 Non-Covered Services

(a) Non-covered services include any service that is not explicitly listed as a covered service above.

(b) Vermont Medicaid does not cover reversal of the surgeries approved under this rule. Cryopreservation, storage, or thawing of reproductive tissue is not covered.

(c) Coverage is not available for surgeries or procedures that are cosmetic, as defined in HCAR 4.104 Medicaid Non-Covered Services, i.e., that change a beneficiary's appearance but are not medically necessary to treat the patient's underlying gender dysphoria.

4.239 In-home Lactation Consultation Services (01/01/2020, GCR 19-058)

4.239.1 Definitions

For the purposes of this rule, the term:

(a) **"Lactation Consultant"** means a healthcare provider who specializes in the clinical management of breastfeeding.

(b) **"International Board Certified Lactation Consultant"** or **"IBCLC"** means a lactation consultant who is certified by the International Board of Lactation Consultant Examiners.

(c) **"Lactation Consultation Services"** means evaluation, education and counseling of a mother and infant's overall breastfeeding readiness, proper breastfeeding techniques, proper use of a breast pump, and other necessary information and assistance to enhance breastfeeding.

4.239.2 Covered Services

Lactation consultation services provided in the home are covered.

4.239.3 Qualified Providers

In-home lactation consultation services must be provided by an IBCLC, who is licensed, working within the scope of his or her practice, and is enrolled in Vermont Medicaid.

4.239.4 Lactation Consultation Services in other locations

Lactation consultation services provided in a facility or office setting are not subject to this rule.

Methods, Standards, and Principles for Establishing
Medicaid Payment Rates for Long-Term Care Facilities

5.101 Definitions

For the purposes of this rule, the term:

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

AICPA means the American Institute of Certified Public Accountants.

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

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

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

Certificate of Need (CON) means certificate of approval for a new institutional health service, issued pursuant to 18 V.S.A. § 9434.

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

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

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

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

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

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

Director means the Director of Rate Setting.

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

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

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

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

FASB means Financial Accounting Standards Board.

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

Free standing facility means a facility that is not hospital-affiliated.

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

Fringe Benefits include benefits such as payroll taxes, workers' compensation, pension, group health, dental and life insurances, profit sharing, cafeteria plans and flexible spending plans, child care for employees, employee parties, and gifts shared by all staff. Fringe benefits may include tuition for college credit in a discipline related to the individual staff member's employment or costs of obtaining a GED.

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

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

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

Hold Day means a day for which the provider is paid to hold a bed open. Hold days are counted as a resident day.

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

Incremental Cost means the added cost incurred in alternative choices.

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

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

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

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

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

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

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

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

OBRA 1987 means the Omnibus Budget Reconciliation Act of 1987.

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

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

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

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

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

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

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

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

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

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

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

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

Secretary means the Secretary of the Agency of Human Services.

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

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

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

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

5.101.1 General Provisions

5.101.1.1 Purpose

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

5.101.1.2 Scope

These rules apply to all privately owned nursing facilities and state nursing facilities providing services to Medicaid residents. Long-term care services in swing-bed hospitals are reimbursed under different methods and standards. Swing-bed hospitals are reimbursed pursuant to 42 U.S.C. § 1396l(b)(1).

5.101.1.3 Authority

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

5.101.1.4 General Description of the Rate Setting System

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

5.101.1.5 Requirements for Participation in Medicaid Program

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

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

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

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

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

(c) Medicaid payments shall not be made to any facility that fails to meet all the requirements of Section 5.101.1.5(a).

5.101.1.6 Responsibilities of Owners

Owners must prudently manage and operate a residential health care program of adequate quality to meet its residents' needs. Regardless of the per diem rate set by the Division, or any other orders made by the Director, Commissioner, or Secretary under these rules the owner of a nursing facility must comply with the requirements and standards of the Agency of Human Services.

5.101.1.7 Duties of the Owner

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

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

(b) Submit cost reports in accordance with the provisions of sections 5.101.3.2 and 5.101.3.3 of these rules and the Nursing Facility Provider Manual.

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

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

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

(f) Notwithstanding any other provision of these rules, any provider that fails to make a complete cost report filing within the time prescribed in section 5.101.3.3(a) or fails to file any other materials requested by the Division within the time prescribed shall receive no increase to its Medicaid rate until the first day of the calendar quarter after a complete cost report or the requested materials are filed, unless within an extension of time previously approved by the Division.

5.101.1.8 Powers and Duties of the Division and the Director

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

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

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

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

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

(f) The Director shall issue, amend, and enforce the Nursing Facility Manual.

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

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

(a) The Division of Licensing and Protection of the Department of Disabilities, Aging and Independent Living shall receive from providers resident assessments on forms it specifies. The Department of Disabilities, Aging and Independent Living shall process this information and shall periodically, but no less frequently than quarterly, provide the Division of Rate Setting with the average case-mix scores of each facility

based on Vermont Medicaid's chosen resident classification system. This score will be used in the quarterly determination of the Nursing Care portion of the rate.

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

5.101.1.10 Computation of and Enlargement of Time, Filing and Service of Documents

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

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

(c) The Division may extend a period of time set in these rules with or without motion or notice for good cause. This section shall not apply to the time limits for appeals to the Vermont Supreme Court or Superior Court from Final Orders of the Division or Final Determinations of the Secretary, which are governed by the Vermont Rules of Appellate Procedure and the Vermont Rules of Civil Procedure respectively.

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

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

5.101.1.11 Representation in All Matters before the Division

A facility may be represented in any matter under this rule as described in the Nursing Facility Provider Manual.

5.101.1.12 Severability

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

5.101.1.13 Effective Date

(a) These rules are effective from January 29, 1992 (as most recently amended July 1, 2024).

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

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

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

(c) If these rules or the Nursing Facility Provider Manual are amended while an administrative proceeding is pending, the Director or Secretary may apply the prior version of the rule or manual if applying the current version would work an injustice or substantial inconvenience.

5.101.2 Accounting Requirements

5.101.2.1 Accounting Principles

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

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

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

and the non-accrual fiscal accounts. The provider shall retain all such documentation for audit purposes.

5.101.2.2 Procurement Standards

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

5.101.2.3 Cost Allocation Plans and Changes in Accounting Principles

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

5.101.2.4 Substance over Form

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

5.101.2.5 Record Keeping and Retention of Records

(a) Each provider must maintain complete documentation of all records that substantiate the data the provider reports to the Division.

(b) Each provider must make all records described in subsection (a) of this section available to the Division of Rate Setting, the federal Department of Health and Human Services, and any authorized representatives of those agencies.

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

(d) The provider shall maintain all such records for at least six years from the date of filing, or the date upon which the fiscal and statistical records were to be filed,

whichever is the later. The Division shall keep all cost reports, supporting documentation submitted by the provider, correspondence, workpapers and other analyses supporting Summaries of Findings for six years. In the event of litigation or appeal involving rates established under these rules, the provider and Division shall retain all records which are in any way related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.

(e) Pursuant to 33 V.S.A. § 908(a), all documents and other materials filed with the Division are public information, except for individually identifiable health information protected by law or the policies, practices, and procedures of the Agency of Human Services.

5.101.3 Financial Reporting

5.101.3.1 Repealed

5.101.3.2 Uniform Cost Reports

Each long-term care facility participating in the Vermont Medicaid program shall annually, or upon request, submit a uniform financial and statistical report (cost report) on forms prescribed by the Division and in accordance with the Nursing Facility Provider Manual.

5.101.3.3 Adequacy and Timeliness of Filing

(a) Providers shall file acceptable cost reports on or before the last day of the fifth month following the close of the period covered by the report, subject to the following exceptions:

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

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

(3) The Division may grant an extension to any facility's filing deadline, as described in the Nursing Facility Provider Manual.

(b) The Division may reject any filing which does not comply with these rules, the cost reporting instructions, or the Nursing Facility Provider Manual. If the Division rejects a cost report filing, the report shall be deemed not filed until the provider files an acceptable cost report that complies with these rules, the cost reporting instructions, and the Nursing Facility provider Manual.

(c) Repealed.

(d) Notwithstanding any other provision of these rules, any provider that fails to make a complete cost report filing within the time prescribed in section 5.101.3.3(a) or within an extension of time approved by the Division shall be subject to the provisions of section 5.101.1.7(f).

5.101.3.4 Review of Cost Reports by Division

(a) Uniform Desk Review

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

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

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

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

(b) On-site Audit

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

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

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

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

5.101.3.5 Settlement of Cost Reports

(a) A cost report is settled if there is no request for reconsideration of the Division's findings or, if such request was made, the Division has issued a final order pursuant to section 5.101.15.3 of these rules.

(b) The Division may correct or reopen a determination or order regarding a cost report, even when it is final, in accordance with the process laid out in the Nursing Facility Provider Manual.

(c) Repealed.

(d) Repealed.

(e) Repealed.

(f) Repealed.

(g) Repealed.

5.101.4 Determination of Allowable Costs for Nursing Facilities

5.101.4.1 Provider Reimbursement Manual and GAAP

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

5.101.4.2 General Cost Principles

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

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

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

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

5.101.4.3 Non-Recurring Costs

Non-recurring costs shall be capitalized and amortized and carried as an on-going adjustment beginning with the first quarterly rate change after the settlement of the cost report for a period of three years as described in the Nursing Facility Provider Manual.

5.101.4.4 Interest Expense

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

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

5.101.4.5 Basis of Property, Plant and Equipment

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

5.101.4.6 Depreciation and Amortization of Property, Plant and Equipment

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

(b) Providers must compute depreciation and amortization in accordance with the Nursing Facility Provider Manual.

(c) Repealed.

(d) The Division shall estimate the useful life of an asset in accordance with the Nursing Facility Provider Manual.

5.101.4.7 Change in Ownership of Depreciable Assets – Sales of Facilities

A facility may qualify for an adjustment in the basis of a depreciable asset after it has changed ownership. The Division's process for recognizing a change of ownership and the according adjustment to a depreciable asset's basis shall be provided in the Nursing Facility Provider Manual.

5.101.4.8 Repealed

5.101.4.9 Leasing Arrangements for Property, Plant and Equipment

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

5.101.4.10 Funding of Depreciation

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

5.101.4.11 Adjustments for Large Asset Acquisitions and Changes of Ownership

(a) Large Asset Acquisitions

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

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

(b) Changes of Ownership

(1) Application shall also be made under this section, no later than 30 days after the execution of a purchase and sale agreement or other binding contract, or the receipt of a Certificate of Need pursuant to 18 V.S.A. §9434, for changes in basis resulting from a change in ownership of depreciable assets recognized by the Division pursuant to section 5.101.4.7. The Division may make related adjustments to the Property and Related rate component.

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

(c) Except in circumstances determined by the Division to constitute an emergency precluding a 60 day notice period, a provider applying for an adjustment pursuant to

this section is required to give 60 days written notice to the Division prior to the purchase of the asset. Such applications shall be exempt from the materiality test set out in section 5.101.8.7(b), but are subject to the other provisions of section 5.101.8.7. The burden is on the provider to document all information applicable to this adjustment and to demonstrate that any costs to be incurred are necessary and reasonable. When applicable, such documentation shall include the Certificate of Need application and all supporting financial information. The Division shall review the application and issue draft findings approving, denying, or proposing modifications to the adjustment applied for within 60 days of receipt of all information required. Providers may request review of the Division's decision in accordance with section 5.101.15 of these rules.

5.101.4.12 Repealed

5.101.4.13 Advertising Expenses

The Division shall recognize reasonable and necessary advertising expenses in accordance with the Nursing Facility Provider Manual.

5.101.4.14 Barber and Beauty Service Costs

The Division shall recognize costs related to barber and beauty services in accordance with the Nursing Facility Provider Manual.

5.101.4.15 Bad Debt, Charity and Courtesy Allowances

Providers shall not include bad debts, charitable donations, or courtesy allowances as allowable costs.

5.101.4.16 Child Day Care

The Division may recognize reasonable and necessary costs related to providing child care services to employees in accordance with the Nursing Facility Provider Manual.

5.101.4.17 Community Service Activities

The Division may recognize costs related to providing community service activities in accordance with the Nursing Facility Provider Manual.

5.101.4.18 Dental Services

The Division shall recognize costs related to dental services in accordance with the Nursing Facility Provider Manual.

5.101.4.19 Legal Costs

The Division shall recognize costs related to legal fees in accordance with the Nursing Facility Provider Manual.

5.101.4.20 Litigation and Settlement Costs

The Division shall recognize litigation and settlement costs, including costs related to challenges of the Division's decisions, in accordance with the Nursing Facility Provider Manual.

5.101.4.21 Motor Vehicle Allowance

The Division shall recognize costs to operate motor vehicles necessary to meet the needs of the facility in accordance with the Nursing Facility Provider Manual.

5.101.4.22 Non-Competition Agreement Costs

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

5.101.4.23 Compensation of Owners, Operators, or their Relatives

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

5.101.4.24 Management Fees and Home Office Costs

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

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

5.101.4.25 Membership Dues

Reasonable and necessary membership dues, including any portions used for lobbying activities, shall be considered Medicaid allowable costs, provided the organization's function and purpose are directly related to providing resident care.

5.101.4.26 Post-Retirement Benefits

The Division may recognize costs related to certain retired personnel in accordance with the Nursing Facility Provider Manual.

5.101.4.27 Public Relations

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

5.101.4.28 Related Party

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

5.101.4.29 Revenues

The Division shall disallow costs related to revenues the facility receives for selling goods or services in accordance with the Nursing Facility Provider Manual.

5.101.4.30 Travel/Entertainment Costs

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

5.101.4.31 Transportation Costs

(a) Costs for ambulance services for emergency transportation or for transportation home from a nursing facility are covered pursuant to other rules adopted by the Agency of Human Services and are not allowable under these rules.

(b) The Division shall recognize costs of transportation that a facility incurs, other than costs described in subsection (a) of this section, in accordance with the Nursing Facility Provider Manual.

5.101.4.32 Services Directly Billable

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

5.101.5 Reimbursement Standards

5.101.5.1 Prospective Case-Mix Reimbursement System

(a) The Division shall operate a prospective case-mix reimbursement system that accounts for some residents being more costly to care for than others. The Division

shall require providers to assess and classify residents in accordance with the Nursing Facility Provider Manual. The Division shall weight the relative costs of caring for different classes of residents to determine an average case-mix score at each facility.

(b) Repealed.

(c) Per diem rates shall be prospectively determined for the rate year based on the allowable operating costs of a facility in a Base Year, plus property and related and ancillary costs from the most recently settled cost report, calculated as described in section 5.101.9.2.

5.101.5.2 Retroactive Adjustments to Prospective Rates

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

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

(1) as an adjustment pursuant to sections 5.101.8 and 5.101.10;

(2) in response to a decision by the Secretary pursuant to section 5.101.15.5 or to an order of a court of competent jurisdiction, whether or not that order is the result of a decision on the merits, or as the result of a settlement pursuant to section 5.101.15.8;

(3) for mechanical computation or typographical errors;

(4) for a terminating facility or a facility in receivership, pursuant to sections 5.101.5.10, 5.101.8.3, and 5.101.10.2;

(5) as a result of revised findings resulting from the reopening of a settled cost report pursuant to section 5.101.3.5;

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

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

(8) when a special rate is revised pursuant to section 5.101.14.1(e)(2).

5.101.5.3 Lower of Rate or Charges

(a) At no time shall a facility's Medicaid per diem rate exceed the provider's average customary charges to the general public for nursing facility services in semi-private rooms at the beginning of the calendar quarter. In this section, "charges" shall mean

the amount actually required to be paid by or on behalf of a resident (other than by Medicaid, Medicare Part A or the Department of Veterans Affairs) and shall take into account any discounts or contractual allowances.

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

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

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

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

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

5.101.5.4 Interim Rates

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

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

5.101.5.5 Repealed

Repealed.

5.101.5.6 Repealed

Repealed.

5.101.5.7 Occupancy Level

(a) A facility should maintain an annual average level of occupancy at a target occupancy established in the Nursing Facility Provider Manual.

(b) For facilities with less than the target occupancy amount, the number of total resident days at the target occupancy amount shall be used, pursuant to section 5.101.7, in

determining the per diem rate for all categories except the Nursing Care and Ancillary categories.

(c) The target occupancy amount provision in paragraph (b) shall be waived for facilities with 20 or fewer beds or terminating facilities pursuant to section 5.101.5.10, and when appropriate, for facilities operating under a receivership pursuant to section 5.101.8.3.

(d) Decreasing the Number of Licensed Beds – For any facility that operated at less than the target occupancy amount during the period used as the cost basis for any rate component subject to subsection (b) which subsequently reduces the number of licensed beds, the minimum occupancy shall be calculated based on the number of the facility's licensed beds on the first day of the quarter after the facility notifies the Division of such reduction.

5.101.5.8 Inflation Factors

The Director shall adjust each component of the rate by an inflation factor in accordance with a procedure established in the Nursing Facility Provider Manual.

5.101.5.9 Costs for New Facilities

(a) For facilities that are newly constructed, newly operated as nursing facilities, or new to the Medicaid program, the prospective case-mix rate shall be determined based on budget cost reports submitted to the Division and the greater of the estimated resident days for the rate year or the resident days equal to the target occupancy amount established under section 5.101.5.7(a) of these rules of all beds used or intended to be used for resident care at any time within the budget cost reporting period. This rate shall remain in effect no longer than one year from the effective date of the new rate. The principles on allowability of costs and existing limits in sections 5.101.4 and 5.101.7 shall apply.

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

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

(d) At the end of the first year of operation, the prospective case-mix rate shall be revised based on the provider's actual allowable costs as reported in its annual cost report filed pursuant to section 5.101.3.2 for its first full fiscal year of operation.

5.101.5.10 Costs for Terminating Facilities

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

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

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

(d) In approving such an application the Division may waive the minimum occupancy requirements in section 5.101.5.7, the limitations on costs in section 5.101.7, or make such other reasonable adjustments to the facility's reimbursement rate as shall be appropriate in the circumstances. The adjustments made under this section shall remain in effect for a period not to exceed six months.

5.101.6 Base Year Cost Categories for Nursing Facilities

5.101.6.1 General

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

5.101.6.2 Nursing Care Costs

Providers shall allot appropriate costs to the Nursing Care component of the rate in accordance with the Nursing Facility Provider Manual.

5.101.6.3 Resident Care Costs

Providers shall allot appropriate costs to the Resident Care component of the rate in accordance with the Nursing Facility Provider Manual.

5.101.6.4 Indirect Costs

Providers shall allot appropriate costs to the Indirect component of the rate in accordance with the Nursing Facility Provider Manual.

5.101.6.5 Director of Nursing

Providers shall allot appropriate costs to the Director of Nursing component of the rate in accordance with the Nursing Facility Provider Manual.

5.101.6.6 Property and Related

Providers shall allot appropriate costs to the Property and Related component of the rate in accordance with the Nursing Facility Provider Manual.

5.101.6.7 Ancillaries

Providers shall allot appropriate costs to the Ancillaries component of the rate in accordance with the Nursing Facility Provider Manual.

5.101.7 Calculation of Costs, Limits and Rate Components for Nursing Facilities

The Division shall calculate base year costs, rates, and category limits pursuant to the Nursing Facility Provider Manual.

5.101.7.1 Repealed

Repealed.

5.101.7.2 Repealed

Repealed.

5.101.7.3 Resident Care Base Year Rate

The Division shall compute Resident Care Base Year rates in accordance with the Nursing Facility Provider Manual.

5.101.7.4 Indirect Base Year Rate

The Division shall compute Indirect Base Year rates in accordance with the Nursing Facility Provider Manual.

5.101.7.5 Director of Nursing Base Year Rate

The Division shall compute the Director of Nursing Base Year per diem rates in accordance with the Nursing Facility Provider Manual.

5.101.7.6 Ancillary Services Rate

The Division shall compute the Ancillary per diem rate in accordance with the Nursing Facility Provider Manual.

5.101.7.7 Property and Related Per Diem

The Division shall compute the Property and Related per diem rate in accordance with the Nursing Facility Provider Manual.

5.101.7.8 Limits Final

Once a final order has been issued for all facilities' Base Year cost reports, notwithstanding any subsequent changes to the cost report findings, resulting from a reopening, appeal, or other reason, any caps on increases in the Nursing Care component, the Resident Care component, or the Indirect component set forth in the Nursing Facility Provider Manual will not change until nursing home costs are rebased pursuant to the Nursing Facility Provider Manual, except for annual adjustment by the inflation factors or a change in law necessitating such a change.

5.101.8 Adjustments to Rates

5.101.8.1 Change in Services

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

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

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

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

5.101.8.2 Change in Law

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

5.101.8.3 Facilities in Receivership

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

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

5.101.8.4 Efficiency Measures

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

5.101.8.5 Interest Rates

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

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

5.101.8.6 Emergencies and Unforeseeable Circumstances

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

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

5.101.8.7 Procedures and Requirements for Rate Adjustments

(a) Providers must apply for rate adjustments in accordance with this rule. The Director shall decide to grant, deny, or grant in part any application for a rate adjustment in their sole discretion.

(b) Except for applications made pursuant to section 5.101.4.11, no application for a rate adjustment should be made if the change to the rate would be smaller than one percent of the rate in effect at the time.

(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 evidence determined necessary for the Division to make a decision.

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

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

(f) The Division shall not be bound in considering other Applications, or in determining the allowability of reported costs, by any prior decision made on any Application under this section. Such decisions shall have no precedential value either for the applicant facility or for any other facility.

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

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

(i) The Division may require an applicant for a rate adjustment under this section or under section 5.101.4.11 to file a budget cost report in support of its application.

(j) When determined to be appropriate by the Division, a budget rate may be set for the facility according to the procedures in and subject to the provisions of section 5.101.5.9. Appropriate cases may include, but are not limited to, changes in the number of beds, major changes in the services delivered to residents, an addition to the facility, or the replacement of existing property.

(k) In calculating an adjustment under this section and section 5.101.4.11, the Division may take into account the effect of such changes on all the cost categories of the facility.

(l) A revision may be made prospectively to a rate adjustment under this section and section 5.101.4.11 based on a "look-back" which will be computed based on a provider's actual allowable costs.

(m) In this section "additional costs" means the incremental costs of providing resident care directly and proximately caused by one of the events listed in this section or section 5.101.4.11. Increases in costs resulting from other causes will not be recognized. It is not intended that this section be used to effect a general rebase in a facility's costs.

5.101.8.8 Limitation on Availability of Rate Adjustments

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

5.101.9 Private Nursing Facility and State Nursing Facility Rates

The Medicaid per diem payment rates for nursing home services are calculated according to the Nursing Facility Provider Manual.

5.101.9.1 Repealed

Repealed.

5.101.9.2 Repealed

Repealed.

5.101.9.3 Repealed

Repealed.

5.101.9.4 State Nursing Facilities

(a) Notwithstanding any other provisions of these rules, payment rates for state nursing facilities shall be determined retrospectively by the Division based on the reasonable and necessary costs of providing those services as determined using the cost reporting and cost finding principles set out in sections 5.101.3 and 5.101.4 of these rules.

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

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

5.101.9.5 Quality Incentives

The Division may make certain awards to facilities that provide a superior quality of care in an efficient and effective manner. The process for making these awards is described in the Nursing Facility Provider Manual.

5.101.10 Extraordinary Financial Relief

5.101.10.1 Objective

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

5.101.10.2 Nature of the Relief

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

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

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

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

5.101.10.3 Criteria to be Considered by the Division

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

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

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

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

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

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

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

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

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

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

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

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

(11) the age and condition of the facility,

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

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

5.101.10.4 Procedure for Application

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

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

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

5.101.11 Payment for Out-of-State Providers

5.101.11.1 Long-Term Care Facilities Other Than Rehabilitation Centers

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

5.101.11.2 Rehabilitation Centers

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

(1) the amount charged; or

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

(a) Payment for Rehabilitation Center services which have not been prior authorized by the Commissioner of the Department of Vermont Health Access or a designee will be made according to section 5.101.11.1.

5.101.11.3 Pediatric Care

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

5.101.12 Rates for ICF/IIDs

Vermont does not currently license any Intermediate Care Facilities for the Intellectually Disabled (ICF/IDs). The Division shall reimburse out-of-state ICF/IDs according to the Medicaid rate established by the state in which the ICF/ID is located.

5.101.12.1 Repealed

Repealed.

5.101.12.2 Repealed

Repealed.

5.101.13 Rates for Swing Beds and Other Long-Term Care Services in Hospitals

Payment for swing-bed and other long-term care services provided by hospitals, pursuant to 42 U.S.C. § 1396l(a), shall be made at a rate equal to the average rate per diem during the previous calendar year under the State Plan to nursing facilities located in the State of Vermont. Supplemental payments made pursuant to section 5.101.14 and section 5.101.9.5 shall not be included in the calculation of swing-bed rates.

5.101.14 Special Rates for Certain Individual Residents

5.101.14.1 Availability of Special Rates for Individuals with Unique Physical Conditions

The Division may grant a special rate for the care of an individual with unique physical conditions whose physical conditions make it otherwise extremely difficult to obtain appropriate long-term care. The process for applying for, calculating, and receiving this special rate is stated in the Nursing Facility Provider Manual.

5.101.14.2 Special Rates for Certain Former Patients of the Vermont State Hospital

The Division may grant a special rate for the care of an individual who was transferred directly from the Vermont State Hospital or to a resident who has a documented history of severe behaviors that prevent them from being placed in a nursing home. The process for applying for, calculating, and receiving this special rate is stated in the Nursing Facility Provider Manual.

5.101.14.3 Special Rates for Medicaid Eligible Individuals in the Custody of the Department of Corrections

The Division may grant a special rate for the care of an individual who is transferred directly from the custody of the Department of Corrections. The process for applying for, calculating, and receiving this special rate is stated in the Nursing Facility Provider Manual.

5.101.15 Administrative Review and Appeals

5.101.15.1 Draft Findings and Decision

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

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

5.101.15.2 Request for an Informal Conference on Draft Findings and Decisions

(a) Within 15 days of receipt of either the draft findings or decision or requested work papers, whichever is the later, a provider that is dissatisfied with the draft findings or decision issued pursuant to section 5.101.15.1(a) may file a written Request for an Informal Conference with the Division's staff on a form prescribed by the Director.

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

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

(c) A Request for an Informal Conference must be pursued before a Request for Reconsideration can be filed pursuant to section 5.101.15.3. Issues not raised in the Request for Informal Conference shall not be raised at the informal conference or in any subsequent proceeding arising from the same action of the Division, including appeals pursuant to 33 V.S.A. §909.

(d) Should no timely Request for an Informal Conference be filed within the time period specified in section 5.101.15.2(a), the Division's draft findings and/or decision are final and no longer subject to administrative review or judicial appeal.

5.101.15.3 Request for Reconsideration

(a) A provider that is aggrieved by an official action issued pursuant to section 5.101.15.2(b) may file a Request for Reconsideration.

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

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

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

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

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

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

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

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

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

(h) The Director shall issue a Final Order on Request for Reconsideration no later than 30 days after the record closes. Pending the issuance of a final order, the official action issued pursuant to section 5.101.15.2(b) shall be used as the basis for setting an interim rate from the first day of the calendar quarter following its issuance. Final orders shall be effective from the effective date of the official action.

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

5.101.15.4 Appeals from Final Orders of the Division

Within 30 days of the date thereof, a nursing facility aggrieved by a Final Order of the Division may file an appeal pursuant to 33 V.S.A. §909(a) and sections 5.101.15.5, 5.101.15.6 and 5.101.15.7 of this rule.

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

(a) No appeal may be taken under this section when the remedy requested is retrospective relief from the operation of a provision of this rule or such other relief as may be outside the power of the Secretary to order. Such relief may be pursued by an appeal to the Vermont Supreme Court or Superior Court pursuant to 33 V.S.A. §909(a)(1) and (2), or prospectively by a request for rulemaking pursuant 3 V.S.A. §806.

(b) Appeals under this section shall be governed by the relevant provisions of the Administrative Procedures Act, 3 V.S.A. §§809-815.

(c) Proceedings under this section shall be initiated by filing two copies of a written Request for Administrative Review with the Division, on forms prescribed therefor.

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

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

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

(1) the simplification of the issues,

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

(3) the appropriateness of prefiled testimony,

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

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

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

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

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

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

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

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

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

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

(n) Parties may appeal the Final Determination of the Secretary pursuant to 33 V.S.A. §909(a)(1) and (2) and sections 5.101.15.6 and 5.101.15.7 of this Rule.

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

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

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

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

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

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

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

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

5.101.15.8 Settlement Agreements

The Commissioner of the Department of Vermont Health Access or their designee may agree to settle reviews and appeals taken pursuant to sections 5.101.15.3 and 5.101.15.5, and, with the approval of the Secretary, may agree to settle other appeals taken pursuant to 33 V.S.A. § 909

and any other litigation involving the Division on such reasonable terms as she or he may deem appropriate to the circumstances of the case.

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

5.102 Definitions

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

AICPA means the American Institute of Certified Public Accountants.

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

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

AOE means the Vermont Agency of Education.

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

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

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

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

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

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

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

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

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

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

DMH means the Department of Mental Health.

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

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

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

FASB means the Financial Accounting Standards Board.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Secretary means the Secretary of the Agency of Human Services.

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

5.102.1 General Provisions

5.102.1.1 Scope and Purpose

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

5.102.1.2 Authority

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

5.102.1.3 General Description of the Rate Setting System

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

5.102.1.4 Requirements for Participation in Medicaid Program

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

5.102.1.5 Prior Authorization of Placement

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

5.102.1.6 Responsibilities of Owners

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

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

5.102.1.7 Duties of the Owner

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.102.1.11 Representation in All Matters Before the Division of Rate Setting

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

5.102.1.12 Severability

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

5.102.1.13 Effective Date

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

5.102.2 Accounting Requirements

5.102.2.1 Accounting Principles

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

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

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

5.102.2.2 Procurement Standards

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

5.102.2.3 Cost Allocations

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

5.102.2.4 Substance Over Form

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

5.102.2.5 Record Keeping and Retention of Records

(a) Each provider must maintain complete documentation of all records that substantiate the data that the provider reports to the Division. Each provider must make all records described in this section available to the Vermont Agency of Human Services, the United States Department of Health and Human Services, and any authorized representative of those agencies.

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

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

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

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

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

5.102.3 Financial Reporting

5.102.3.1 Repealed

Repealed.

5.102.3.2 Funding Application and Financial Reporting

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

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

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

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

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

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

(2) depreciation schedule,

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

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

(5) Repealed.

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

(7) Repealed.

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

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

(10) Repealed.

(11) Repealed.

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

5.102.3.3 Adequacy and Timeliness of Filing

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

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

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

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

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

5.102.3.4 Review of Funding Applications by Division

(a) Desk Review

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

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

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

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

(b) On-site Audit

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

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

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

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

5.102.3.5 Settlement of Funding Applications

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

5.102.4 Determination of Allowable Costs

5.102.4.1 Incorporation of Provider Reimbursement Manual

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

5.102.4.2 General Cost Principles

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

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

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

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

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

(1) direct qualified staff salaries and benefits,

(2) other direct program costs,

(3) direct program administrative costs and

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

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

5.102.4.3 Preapproval by PADs

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

5.102.4.4 Non-Recurring Costs

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

5.102.4.5 Property and Related Costs

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

5.102.4.6 Interest Expense

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

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

5.102.4.7 Basis of Property, Plant and Equipment

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

5.102.4.8 Depreciation and Amortization of Property, Plant and Equipment

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

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

5.102.4.9 Funding of Depreciation

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

5.102.4.10 Leasing Arrangements for Property, Plant and Equipment

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

5.102.4.11 Legal and Litigation Costs

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

5.102.4.12 Compensation of Owners, Operators, or their Relatives

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

5.102.4.13 Management Fees and Central Office Costs

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

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

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

5.102.4.14 Advertising and Public Relations

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

5.102.4.15 Bad Debts, Charity, and Courtesy Allowances

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

5.102.4.16 Related Party

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

5.102.4.17 Applied Revenues

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

5.102.4.18 Travel/Entertainment Costs

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

5.102.4.19 Transportation Costs

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

5.102.4.20 Costs for New Programs and Start-Up Costs

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

5.102.4.21 Compensation Limitations

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

5.102.5 Classification of Costs and Assignment to Service Categories

5.102.5.1 General

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

5.102.5.2 Repealed

Repealed.

5.102.5.3 Service and Administration Categories

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

(a) Service Categories

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

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

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

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

5.102.6 Reimbursement Standards

5.102.6.1 Prospective Reimbursement System and the Per Diem Rate

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

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

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

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

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

5.102.6.2 Temporary Absences

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

5.102.6.3 Retroactive Adjustments to Prospective Rates

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

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

(1) as an adjustment pursuant to section 5.102.9;

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

(3) for mechanical computation or typographical errors;

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

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

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

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

5.102.6.4 Interim Rates

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

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

5.102.6.5 Base Year

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

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

(c) Repealed.

5.102.6.6 Occupancy Level

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

5.102.6.7 Inflation Factors

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

5.102.6.8 Cap on Increases from Prior Year to Current Base Year

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

5.102.7 Calculation of Costs, Limits and Rates for PNMI Facilities

5.102.7.1 Repealed

Repealed.

5.102.7.2 Approved Program Costs

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

5.102.7.3 Repealed

Repealed.

5.102.7.4 Repealed

Repealed.

5.102.7.5 Calculation of Per Diem Rates for Crisis/Stabilization Programs

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

5.102.7.6 Recapture of Net PNMI Revenue in Excess of Five Percent

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

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

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

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

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

5.102.8 Adjustments to Rates

5.102.8.1 Procedures and Requirements for Rate Adjustments

Providers may apply for rate adjustments during the rate year.

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

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

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

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

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

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

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

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

5.102.8.2 Approval of Applications

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

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

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

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

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

5.102.8.3 Limitations on Availability of Rate Adjustments

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

5.102.9 Extraordinary Financial Relief

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

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

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

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

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

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

5.102.10 Limitations on Payments

5.102.10.1 Contract Maximum

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

5.102.10.2 Upper Payment Limits

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

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

5.102.10.3 Lower of Rate or Charges

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

5.102.11 Payment for Interstate Placements

5.102.11.1 Out-of-State Services

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

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

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

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

5.102.12 Administrative Review and Appeals

5.102.12.1 Draft Findings and Decisions

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

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

5.102.12.2 Request for an Informal Conference on Draft Findings and Decisions

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

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

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

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

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

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

5.102.12.3 Request for Reconsideration

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

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

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

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

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

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

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

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

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

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

5.102.12.4 Request for Administrative Review

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

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

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

5.102.12.5 General Provisions

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

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

Medicaid Cost Sharing

6.100 Medicaid Cost Sharing (06/01/2018, GCR 17-090)

6.100.1 Cost sharing, including deductibles, co-insurance, or copayments, is charged to Medicaid beneficiaries as set forth in this rule.

6.100.2 Copayment Requirements

(a) Medicaid enrolled beneficiaries are subject to the following copayment requirements, unless they are exempt under section 6.100.3 of this rule.

(1) Outpatient Services: $3.00 per day per hospital for outpatient hospital services.

(2) Dental services: $3.00 per provider per date of service.

(3) Prescription drugs (original or refill):

(A) $1.00 for each prescription with a Medicaid reimbursement rate of less than $30.00, or
(B) $2.00 for each prescription with a Medicaid reimbursement rate of $30.00 or more, but less than $50.00, or
(C) $3.00 for each prescription with a Medicaid reimbursement rate of $50.00 or more.

(b) Copayments are a portion of the Medicaid rate and are deducted from the Medicaid payment for each service that is subject to cost sharing, regardless of whether the provider has collected the payment or waived the cost sharing.

(c) If a beneficiary is unable to pay the copayment, providers shall not deny medical services.

(d) A beneficiary's inability to pay does not eliminate his or her liability for the copayment amount. Providers may bill a beneficiary for unpaid copayments.

(e) The State is not responsible for copayments that a provider may collect in error or that an individual makes on a service that is not paid for by Vermont Medicaid.

6.100.3 Copayment Exemptions

(a) Copayments are never required from Medicaid beneficiaries who are:

(1) Under age 21.

(2) Pregnant, through the duration of their pregnancy and through the end of the calendar month during which the 60th day following the end of pregnancy occurs.

(3) Receiving Medicaid coverage of long-term care services and supports in a long-term care facility.

(4) Otherwise exempt from cost sharing by federal regulation at 42 CFR §447.56(a)(1).

(b) For beneficiaries also covered by Medicare, the prescription drug copays in 6.100.2(a)(3) do not apply to prescriptions covered by Medicare Part D plans.

(c) The following services are exempt from copayments:

(1) Sexual assault-related services.

(2) Services otherwise exempt from cost sharing by federal regulation at 42 CFR §447.56(a)(2).

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7.100.1 Developmental Disabilities Services Purpose and Scope (03/01/2023, GCR 23-024)

(a) The purpose of these regulations is to fulfill the requirements of the Developmental Disabilities Act of 1996 (DD Act) (18 V.S.A Chapter 204A) to include specific details for implementation of the Act. These rules are adopted pursuant to 18 V.S.A. § 8726.

(b) The Developmental Disabilities Services program operates within the State's Global Commitment to Health 1115 Waiver, providing long-term services and supports to individuals with developmental disabilities.

(c) The Program is subject to approval by the Centers for Medicare and Medicaid Services (CMS) and is managed in compliance with CMS terms and conditions of participation.

7.100.2 Definitions

The following terms are defined for the purpose of these regulations.

(a) **"Adult"** means a person age 18 or older. The term includes people age 18 or older who attend school.

(b) **"Agency"** means the responsible designated agency or specialized service agency.

(c) **"Applicant"** means a person who files a written application for services, supports or benefits in accordance with 7.100.5 of these regulations. If the applicant is a guardian or family member or a designated agency, the term "applicant" also includes the person with a developmental disability.

(d) **"Authorized Funding Limit"** (AFL) means all funding related to an individual's home and community-based services budget, including the administration amount available to transfer (as specified in division policy), but does not include: funding for state and local crisis services, the employment program base and statewide communication resources.

(e) "**Authorized Representative"** means an individual or organization, either appointed, by an applicant or beneficiary, or authorized under State or other applicable law, to act on behalf of the applicant or beneficiary in assisting with the application and renewal of eligibility, the internal appeal, grievance, or State fair hearing processes, and in all other matters with the Department, as permitted under 42 CFR § 435.923. Unless otherwise stated in law, the authorized representative has the same rights and responsibilities as the applicant or beneficiary in obtaining a benefit determination and in dealing with the internal appeal, grievance, and State fair hearing processes.

(f) **"Certification"** means the process by which the Department of Disabilities, Aging, and Independent Living determines whether a provider meets minimum standards for receiving funds it administers to provide services or supports to people with developmental disabilities.

(g) **"Certified provider"** means an agency that has as one of its primary purposes to deliver services and supports for people who have developmental disabilities and that currently is certified by the Department of Disabilities, Aging and Independent Living in accordance with 7.100.11 of these regulations.

(h) **"Clinical Services"** means assessment; individual, family and group therapy; and medication or medical services provided by clinical or medical staff, including a qualified clinician, therapist, psychiatrist, or nurse. Clinical Services are medically necessary services and equipment (such as dentures, eyeglasses, assistive technology) that cannot be accessed through the Medicaid State Plan.

(i) **"Commissioner"** means the Commissioner of the Department of Disabilities, Aging, and Independent Living.

(j) **"Community Supports"** means support provided to assist individuals to develop skills and social connections. The supports may include teaching and/or assistance in daily living, support to participate in community activities, and building and sustaining healthy personal, family and community relationships. Community Supports may involve individual supports or group supports (two or more people). Community supports includes transportation to access the community. Supports must be provided in accordance with the desires of the individual and their Individual Support Agreement and take place within settings that afford opportunities for choice and inclusion that are consistent with federal home and community-based services rules.

(k) **"Crisis Services"** means time-limited, intensive supports provided for individuals who are currently experiencing, or may be expected to experience, a psychological, behavioral, or emotional crisis. Crisis Services may include crisis assessment, support and referral or crisis beds and may be individualized, regional, or statewide.

(l) **"Day"** means calendar day, not business day, unless otherwise specified.

(m) **"Department"** means the Department of Disabilities, Aging, and Independent Living.

(n) **"Designated Agency"** (DA) means an agency designated by the Department, pursuant to 18 V.S.A. § 8907, and the regulations implementing that law, to oversee, provide and ensure the delivery of services and/or service authorizations for eligible individuals with developmental disabilities in an identified geographic area of the state. The requirements for being a DA are explained in the Department's *Administrative Rules on Agency Designation*.

(o) **"Developmental Disability"** (DD) means an intellectual disability or an autism spectrum disorder which occurred before age 18 and which results in significant deficits in adaptive behavior that manifested before age 18 (See 7.100.3). Temporary deficits in cognitive functioning or adaptive behavior as the result of severe emotional disturbance before age 18 are not a developmental disability. The onset after age 18 of impaired intellectual or adaptive functioning due to drugs, accident, disease, emotional disturbance, or other causes is not a developmental disability.

(p) **"Division"** means the Developmental Disabilities Services Division (DDSD) within the Department.

(q) **"Employment Supports"** means support provided to assist transition age youth and adults in Establishing and achieving work and career goals. Employment supports include assessment, employer and job development, job training and ongoing support to maintain a job, and may include environmental modification, adaptive equipment, and transportation, as necessary.

(r) **"Family"** means a group of individuals that includes a person with a developmental disability and that is related by blood, marriage, or adoption or that considers itself a family based upon bonds of affection, which means enduring ties that do not depend upon the existence of an economic relationship.

(s) **"Fiscal/Employer Agent"** (F/EA**)** means an organization that is:

(1) Qualified under Internal Revenue Service rules to pay taxes and provide payroll services for employers as a fiscal agent; and

(2) Under contract with the Department to handle payroll duties for shared living providers who hire workers and recipients or families who choose to self/family-manage or share-manage services.

(t) **"Global Commitment to Health Section 1115 Demonstration ("Demonstration")"** means the Section 1115 Demonstration under which the Federal government waives certain Medicaid coverage and eligibility requirements found in Title XIX of the Social Security Act.

(u) **"Home and Community-Based Services"** (HCBS) means an array of long term services developed to support individuals to live and participate in their home and community rather than in an institutional setting, consistent with Centers for Medicare and Medicaid Services (CMS) federal HCBS Rules.

(v) **"Home Supports"** means services, supports and supervision provided for individuals in and around their residences up to 24 hours a day, seven days a week (24/7). Services include support for individuals to acquire and retain life skills and improve and maintain opportunities and experiences for individuals to be as independent as possible in their home and community. Services include maintaining health and safety and home modifications required for accessibility related to an individual's disability, including cost-effective technology that promotes safety and independence in lieu of paid direct support. Home supports must be in compliance with HCBS rules which emphasize choice, control, privacy, tenancy rights, autonomy, independence and inclusion in the community.

(w) **"Individual"** means a young child, a school-age child or an adult with a developmental disability.

(x) **"Individual Support Agreement"** (ISA) means the agreement between an individual and an agency or Supportive Intermediary Service Organization that describes the plan of services and supports.

(y) **"In-service training"** means training that occurs after a worker has been employed or is under contract. In-service training is intended to promote professional development and increase skills and knowledge.

(z) **"Network"** means providers enrolled in the Vermont Medicaid program who are designated by the Commissioner to provide or arrange developmental disabilities services and who provide services on an ongoing basis to recipients.

(aa) **"Pre-service training"** means training that occurs before workers are alone with a person with developmental disabilities.

(bb) **"Provider"** means a person, facility, institution, partnership, or corporation licensed, certified or authorized by law to provide health care service to a recipient during that individual's medical care, treatment or confinement. A provider cannot be reimbursed by Medicaid unless they are enrolled with Medicaid; however, a provider may enroll to serve only a specific recipient. A shared living provider, employee of a shared living provider, or an individual or family that self/family-manages services is not a provider for purposes of these regulations.

(cc) **"Psychologist"** means a person licensed to practice psychology in the state where the evaluation occurred.

(dd) **"Qualified Developmental Disabilities Professional"** (QDDP) means a person who meets the Department's qualifications as specified in Department policy for education, knowledge, training, and experience in supporting people with developmental disabilities and their families.

(ee) **"Recipient"** means a person who meets the criteria contained in these regulations, and who has been authorized to receive funding or services, or a family that has been approved to receive funding or services under criteria specified in these regulations.

(ff) **"Resident"** means a person who is physically present in Vermont and intends to remain in Vermont and to make his or her home in Vermont, except a resident may also be:

(1) A person placed in an out of state institution, as defined by Health Benefits Eligibility and Enrollment (HBEE) Rule 3.00, by a department of the State of Vermont, or

(2) A person placed and supported in an unlicensed home in an adjoining state by a Vermont agency, or

(3) A person who meets criteria listed in 7.100.4 (b).

(gg) **"Respite Supports"** means alternative caregiving arrangements for family members or shared living providers/foster families and the individual being supported, on an intermittent or time limited basis, because of the absence of or need for relief of those persons normally providing the care to the individual, when the individual needs the support of another caregiver.

(hh) **School-age child"** means a child age 6 and younger than age 18.

(ii) **"Self/family-managed"** services means the recipient or his or her family plans, establishes, coordinates, maintains, and monitors all developmental disabilities services and manages the recipient's budget within federal and state guidelines.

(jj) **"Self/family-managed worker"** means a person who is employed or contracted and directed by a recipient or by a family member and paid with Department funds to provide supports or services for the recipient.

(kk) **"Service"** means a benefit:

(1) Covered under the Global Commitment to Health Section 1115 Demonstration as set out in the Special Terms and Conditions approved by CMS,
(2) Included in the State Medicaid Plan if required by CMS,
(3) Authorized by state regulation or law, or
(4) Identified in the Intra-governmental Agreement (IGA) between DVHA and the Agency of Human Services (AHS), DVHA and the departments within AHS, or DVHA and the Agency of Education for the administration and operation of the Global Commitment to Health Section 1115 Demonstration.

(ll) **"Service Coordination"** means assistance to recipients in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports for a specific individual. Service Coordination responsibilities include:

(1) Developing, implementing and monitoring the ISA
(2) Coordinating medical and clinical services
(3) Establishing and maintaining a case record
(4) Reviewing and signing off on critical incident reports
(5) Providing general oversight of services and supports

The provision of Service Coordination will be consistent with the HCBS requirements for conflict-free case management.

(mm) **"Shared management of services"** means that the recipient or his or her family manages some but not all Medicaid-funded developmental disabilities services, and an agency manages the remaining services.

(nn) **"Special care procedure"** means nursing procedures that a lay individual (a person who is not a qualified health professional) does not typically have the training and experience to perform.

(oo) **"Specialized service agency"** (SSA) means an agency designated by the Department that meets criteria for contracting with the Department as an SSA, as described in the Department's *Administrative Rules on Agency Designation*, and that contracts with the Department to provide services to individuals with developmental disabilities.

(pp) **"Supportive Intermediary Service Organization"** (Supportive ISO) means an organization under contract with the Department to provide support to individuals and families to learn and understand the responsibilities of self/family-managed services.

(qq) **"Supportive Services"** means therapeutic services that cannot be accessed through State Plan Medicaid. These are therapeutically or medically appropriate services that include behavior support and consultation; assessment, consultation and training for communication supports; skills-based training such as dialectical behavior therapy skills groups or sexuality groups. This includes other therapeutic or medically appropriate services not covered under State Plan Medicaid when provided by licensed or certified individuals (such therapeutic horseback riding).

(rr) **"System of Care Plan"** means the plan required by 18 V.S.A. §8725 describing the nature, extent, allocation and timing of services that will be provided to people with developmental disabilities and their families.

(ss) **"Transportation Services"** means acquisition and maintenance of accessible transportation for an individual living with a home provider or family member or reimbursement for mileage for transportation to access Community or Employment Supports.

(tt) **"Worker"** means any employee or contractor compensated with funds paid or administered by the Department to provide services to one or more people with a developmental disability. Professionals, such as nurses or psychologists practicing under a license granted by the State of Vermont are not included within this definition. Family-hired respite workers paid by Flexible Family Funding are not included within this definition.

(uu) **"Young child"** means a person who is under age 6.

7.100.3 Criteria for determining developmental disability

(a) Young child with a developmental disability defined.

A young child with a developmental disability is a child who has one of the three following conditions:

(1) A diagnosed physical or mental condition so severe that it has a high probability of resulting in intellectual disability. This includes conditions such as:

Anoxia
Congenital or degenerative central nervous system disease (such as Tay Sachs syndrome)
Encephalitis
Fetal alcohol syndrome
Fragile X syndrome
Inborn errors of metabolism (such as untreated PKU)
Traumatic brain injury
Shaken baby syndrome
Trisomy 21, 18, and 13
Tuberous sclerosis

(2) A condition of clearly observable and measurable delays in cognitive development and significant, observable and measurable delays in at least two of the following developmental domains:

Communication
Social/emotional Motor
(physical)
Self-help skills

(3) An autism spectrum disorder (7.100.3(h)-(j)) resulting in significant, observable and measurable delays in at least two of the following developmental domains:

Communication
Social/emotional Motor
(physical)
Self-help skills.

(b) Criteria for assessing developmental disability in a young child.

(1) The diagnosis of a condition which has a high probability of resulting in intellectual disability (7.100.3(a)(1)) must be made by a physician.

(2) The documentation of delays in cognitive and other developmental domains (7.100.3(a) (2)-(3)) must be made through a family-centered evaluation process which includes the family. The evaluation process must include:

(A) Observations and reports by the family and other members of the assessment team, such as a physician, behavior consultant, psychologist, speech therapist, audiologist, physical therapist, occupational therapist, childcare provider, representative from the Children's Integrated Services - Early Intervention (CIS-EI) Team, representative from Early Childhood

Special Education (ECSE), representative from Children with Special Health Needs, representative from an agency;

(B) A review of pertinent medical/educational records, such as assessments used to determine eligibility for CIS-EI and ECSE, as needed; and

(C) Appropriate screening and assessment instruments.

(3) The diagnosis of autism spectrum disorder must be made according to 7.100.3(h)-(j).

(c) School-age child or adult with developmental disability defined.

(1) A school-age child (age 6 and younger than age 18) or adult with a developmental disability is an individual who:

(A) Has intellectual disability (7.100.3(d)-(f)) or autism spectrum disorder (7.100.3(h)-(j)) which manifested before age 18 (7.100.3(m)); and

(B) Has significant deficits in adaptive behavior (7.100.3(k)-(l)) which manifested before age 18 (7.100.3(m)).

(2) Temporary deficits in cognitive functioning or adaptive behavior as the result of severe emotional disturbance before age 18 are not a developmental disability. The onset after age 18 of impaired intellectual or adaptive functioning due to drugs, accident, disease, emotional disturbance, or other causes is not a developmental disability.

(d) Intellectual disability defined.

(1) **"Intellectual disability"** means significantly sub-average cognitive functioning that is at least two standard deviations below the mean for a similar age normative comparison group. On most tests, this is documented by a full-scale score of 70 or below, or up to 75 or below when taking into account the standard error of measurement, on an appropriate norm-referenced standardized test of intelligence and resulting in significant deficits in adaptive behavior manifested before age 18.

(2) **"Intellectual disability"** includes severe cognitive deficits which result from brain injury or disease if the injury or disease resulted in deficits in adaptive functioning before age 18. A person with a diagnosis of "learning impairment" has intellectual disability if the person meets the criteria for determining "intellectual disability" outlined in 7.100.3(e).

(e) Criteria for determining whether a school-age child or adult has intellectual disability.

(1) The determination of whether a school-age child or adult has intellectual disability for the purpose of these regulations requires documentation of the following components:

(A) Significantly sub-average cognitive functioning (7.100.3(d) and (f));

(B) Resulting in significant deficits in adaptive behavior; and (7.100.3(k)-(l))

(C) Manifested before age 18 (7.100.3(m)).

(2) The criteria for determining whether a school-aged child or adult has an intellectual disability is as defined in these regulations as outlined in 7.100.3(e-f) and not as described in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(f) Process for determining whether a school-aged child or adult has an intellectual disability.

(1) To determine whether or not a school-age child or adult has intellectual disability, a psychologist must:

(A) Personally perform, supervise, or review assessments that document significantly sub-average cognitive functioning and deficits in adaptive behavior manifested before age 18; and

(B) Integrate current and past test results with other information about the individual's abilities in arriving at a determination.

(2) The most universally used standardized intelligence test for school-aged children up to age 16 is the Wechsler Intelligence Scale for Children (WISC), current edition. The most universally used measure for children over age 16 and adults is the Wechsler Adult Intelligence Scale (WAIS), current edition. For people with language, motor, or hearing disabilities, a combination of assessment methods must be used, and the psychologist must use clinical judgment to determine the best tests to use for the individual. Diagnosis based on interpretation of test results takes into account a standard error of measurement for the test used.

(3) A determination that a person has intellectual disability for the purpose of these regulations must be based upon current assessment of cognitive functioning *and* a review of any previous assessments of cognitive functioning. It is the responsibility of the psychologist to decide whether new cognitive testing is needed. In general, for school-aged children, "current" means testing conducted within the past three years. For adults, "current" means cognitive testing conducted in late adolescence or adulthood. Situations where new testing may be indicated include the following:

(A) There is reason to believe the original test was invalid (e.g., the person was sick, was not wearing glasses, was in the midst of a psychiatric crisis, etc.).

(B) The individual has learned new skills which would significantly affect performance (such as improved ability to communicate).

(C) The individual had mild intellectual disability on a previous test and has since made gains in adaptive behavior.

(4) If IQ testing of the person has resulted in some Full-Scale IQ (FSIQ) scores above 70 and some FSIQ scores below 70, taking into account the standard error of measurement, it is the responsibility of the psychologist to determine which FSIQ scores are the best estimate of the person's cognitive ability. When there is a wide variation between test scores, the psychologist should render his/her clinical opinion, including the rationale, regarding which FSIQ scores are the best estimate of the person's cognitive ability. A determination that a person has intellectual disability for the purpose of these regulations cannot be made if all of the person's FSIQ test scores are greater than75.

(5) The diagnosis in questionable cases should be based upon scores over time and multiple sources of measurement.

(6) The diagnosis of intellectual disability must not be based upon assessments conducted when the individual was experiencing a short-term psychiatric, medical, or emotional crisis which could affect performance. Cognitive testing should not ordinarily be performed when a person is in the midst of a hospital stay.

(7) If the psychologist determines that standardized intellectual testing is inappropriate or unreliable for the person, the psychologist can make a clinical judgment based on other information, including an adaptive behavior instrument.

(g) Criteria for determining whether a school-age child or adult has an autism spectrum disorder and is a person with a developmental disability.

The determination of whether a school-age child or adult has an autism spectrum disorder and is a person with a developmental disability for the purpose of these regulations requires documentation of the following components:

(1) Diagnosis of an autism spectrum disorder made according to process outlined in 7.100.3(h)-(j)

(2) Resulting in significant deficits in adaptive behavior (7.100.3(k)-(l)); and

(3) Manifested before age 18 (7.100.3(m)).

(h) Autism spectrum disorder defined.

Autism spectrum disorder means the same as it is defined in the current DSM. People receiving services as of October 1, 2017, who were found eligible with a diagnosis of pervasive developmental disorder under previous versions of the DSM continue to be eligible for services if they continue to present the symptoms that resulted in the diagnosis. Autism spectrum disorder means the same as the term "autism" in the Developmental Disabilities Act.

(i) Criteria for determining whether a person has autism spectrum disorder.

(1) The diagnostic category of autism spectrum disorder includes considerable variability in the presence and intensity of symptoms. Many of the symptoms of autism spectrum disorder overlap with other childhood diagnoses. Because of the complexity in differentially diagnosing autism spectrum disorder, it is essential that clinicians rendering these diagnoses have specific training and experience in child development, autism spectrum disorder, other developmental disorders, and other childhood psychiatric disorders.

(2) Preferably a comprehensive diagnostic evaluation is conducted by an interdisciplinary team of professionals with specific experience and training in diagnosing autism spectrum disorder. In the absence of an interdisciplinary team, a single clinician with the qualifications listed below may conduct a multidisciplinary assessment integrating information from other professionals.

(3) At a minimum, an evaluation must be performed by a single clinician who has the following qualifications or an interdisciplinary team that includes:

(A) A board certified or board eligible psychiatrist; or

(B) A psychologist; or

(C) A board certified or board eligible neurologist or developmental-behavioral or neurodevelopmental disabilities pediatrician.

(4) The psychiatrist, psychologist, neurologist, or pediatrician must have the following additional experience and training:

(A) Graduate or post-graduate training encompassing specific training in child development, autism spectrum disorder, and other developmental and psychiatric disorders of childhood, and a process for assessment and differential diagnosis of autism spectrum disorder; or supervised clinical experience in the assessment and differential diagnosis of autism spectrum disorder;

(B) Training and experience in the administration, scoring and interpreting of psychometric tests, or training in understanding and utilizing information from psychometric testing in the diagnosis of autism spectrum disorder; and

(C) Experience in the evaluation of individuals with the age range of the person being evaluated.

(5) Clinicians must follow the ethical guidelines for their profession regarding practicing within their area of expertise and referring to other professionals when needed. When a single clinician is conducting the assessment, he or she should determine whether other professionals need to evaluate the person to gain additional information before rendering a diagnosis. Additional evaluators may include psychologists, speech language pathologists, medical sub-specialists, developmental-behavioral or neurodevelopmental disabilities pediatricians, occupational therapists, psychiatrists, and neurologists.

(6) In the event a shortage of qualified assessors prevents timely evaluations, the state will assist agencies to identify available qualified assessors or may, in its discretion, waive the provision of rule(i)(4).

(j) Essential components of an assessment to determine autism spectrum disorder.

New applicants must be assessed using the DSM criteria in effect at the time of application. An assessment to determine whether an individual has an autism spectrum disorder must include all of the following components:

(1) Comprehensive review of history from multiple sources, including developmental history, medical history, psychiatric history with clarification of prior diagnoses, educational history, and family history;

(2) Systematic autism spectrum disorder diagnostic interview with primary caregivers;

(3) A systematic observation with the individual to assess social interaction, social communication, and presence of restricted interests and behaviors;

(4) For older children and adults who can report symptoms, a systematic clinical interview;

(5) Referral for multidisciplinary assessment, as indicated;

(6) Comprehensive clinical diagnostic formulation, in which the clinician weighs all the information from (7.100.3(j)(1) through (5), integrates findings and provides a well-formulated differential diagnosis using the criteria in the current version of the DSM; and

(7) Current assessments based upon the individual's typical functioning.

(A) A determination of autism spectrum disorder for the purpose of these regulations must be based upon current assessment. It is the responsibility of the clinician or team performing the assessment to decide whether new observations or assessments are needed. In general, for school-age children, "current" means a comprehensive assessment conducted within the past three years. However, for school-age children applying for limited services such as Flexible Family Funding, Targeted Case Management, the Bridge Program, or Family Managed Respite, "current" means a comprehensive assessment conducted any time prior to age 18; for such children, a new assessment is required if the DA believes the child may not have autism spectrum disorder or when applying for HCBS.

(B) The initial diagnosis of autism spectrum disorder must not be based upon assessments and observations conducted when the individual is experiencing a psychiatric, medical or emotional crisis or when a person is in the midst of a hospital stay. Further assessment should be completed when the person stabilizes and/or returns to the community.

(C) For adults, "current" means a comprehensive assessment conducted in late adolescence or adulthood and adaptive testing within the past three years. Situations where new testing may be indicated include the following:

(i)The individual has learned new skills which would significantly affect performance (such as improved ability to communicate).

(ii)New information indicates that an alternate diagnosis better explains the individual's functioning and behavior.

(k) Significant deficits in adaptive behavior defined.

Significant deficits in adaptive behavior means deficits in adaptive functioning which result in an overall composite score on a standardized adaptive behavior scale at least two standard deviations below the mean for a similar age normative comparison group. On most tests, this is documented by an overall composite score of 70 or below, taking into account the standard error of measurement for the assessment tool used.

(l) Criteria for assessing adaptive behavior in a school-age child or adult.

(1) Adaptive functioning must be measured by the current version of a standardized norm-referenced assessment instrument. The assessment tool must be standardized with reference to people of similar age in the general population. Adaptive functioning must not be measured with an instrument that is norm-referenced only to people in institutions or people with intellectual disability or autism spectrum disorder.

(2) The assessment instrument must be completed by a person qualified to administer, score, and interpret the results as specified in the assessment tool's manual. The administration of the tool must follow the protocol for administration specified in the assessment tool's manual.

(3) The assessment must be current. A current assessment is one which was completed within the past three years, unless there is reason to think the individual's adaptive functioning has changed.

(4) Based upon the assessment, the evaluator must determine whether the person is performing two or more standard deviations below the mean with respect to adaptive functioning, compared to a national sample of similar-aged people.

(5) Ordinarily, assessments must be based upon the person's usual level of adaptive functioning. Assessments should not ordinarily be performed when the individual is in the midst of an emotional, behavioral or health crisis, or must be repeated once the individual stabilizes. An assessment performed while the individual was in a nursing facility or residential facility must be repeated when the individual is in a community setting.

(6) It is the responsibility of the psychologist to ensure that the adaptive behavior assessment is based upon information from the most accurate and knowledgeable informant available. It may be necessary to integrate information on adaptive functioning from more than one informant.

(m) Manifested before age 18

Manifested before age 18 means that the impairment and resulting significant deficits in adaptive behavior were observed before age 18. Evidence that the impairment and resulting significant deficits in adaptive behavior occurred before the age 18 may be based upon records, information provided by the individual, and/or information provided by people who knew the individual in the past.

(n) Nondiscrimination in assessment

Assessment tools and methods must be selected to meet the individual needs and abilities of the person being assessed.

(1) People whose background or culture differs from the general population must be assessed with methods and instruments that take account of the person's background.

(2) A person must be assessed in the language with which he or she communicates most comfortably.

(3) People with language, motor, and hearing disabilities must be assessed with tests which do not rely upon language, motor ability, or hearing.

(4) If a person uses hearing aids, glasses, or other adaptive equipment to see, hear, or communicate, the evaluator must ensure that the individual has access to the aids or adaptive equipment during the evaluation.

(5) If a person uses a language interpreter or a method of augmentative and alternative communication and or needs a personal assistant for communication, the evaluator (e.g., the psychologist) is responsible for deciding how best to conduct the overall assessment in order to achieve the most authentic and valid results. However, scores for standardized tests are valid only if testing was performed in accordance with the criteria set forth in the test manual.

(o) Missing information to document developmental disability

There may be circumstances in which considerable effort is made to obtain all the required history and documentation to determine whether a person has a developmental disability, but the required information cannot be obtained. This may include situations in which there are no available informants to document a person's functioning prior to age 18, previous records cannot be obtained, or do not exist. In these circumstances, the determination of whether the person meets the criteria for having a developmental disability should be based upon the current assessment and all available information, including other life factors that occurred after age 18 that could potentially impact cognitive, adaptive, or other functioning.

7.100.4 Recipient Criteria

(a) Who can be a recipient

(1) A recipient is an individual with a developmental disability, as defined in 7.100.2 (o) and (ee), who has been authorized to receive funding or services, or a family that has been approved to receive funding or services under criteria specified in these regulations.

(2) Services or supports to a family member of a recipient must be in the context of supporting the recipient and are for the purpose of assisting the family to provide care and support for their family member with a developmental disability.

(b) Recipients must be Vermont residents

(1) A recipient must be a resident of Vermont as defined in 7.100.2(ff). In the case of a minor child, at least one custodial parent of the child must be a resident of Vermont.

(2) A person or family who leaves Vermont for a vacation, visit, temporary move, or trial move may continue to be a recipient for a period not to exceed six months.

(c) Exceptions

The Commissioner may make exceptions to the requirements of the program access criteria in 7.100.4(a), in order to promote the purposes of the Developmental Disabilities Act, if the exception will not deprive other people who meet the criteria for being recipients of needed services or benefits (e.g., when funds are provided by another state, or by another Vermont state agency or department).

(d) People receiving services on July 1, 1996

People with developmental disabilities who were receiving services on July 1, 1996, may continue to receive services consistent with their needs and the System of Care Plan and these regulations.

(e) Eligibility after leave of service

Any person who leaves services for one year or longer for any reason and later reapplies for services must be assessed based upon the eligibility criteria in effect on the date of the person's reapplication.

7.100.5 Application, Assessment, Funding Authorization, Programs and Funding Sources, Notification, Support Planning and Periodic Review

(a) Who may apply

(1) Any person who believes he or she has a developmental disability or is the family member or authorized representative of such a person may apply for services, supports, or benefits. In addition, the guardian of the person may apply.

(2) Any other person may refer a person who may need services, supports, or benefits.

(3) An agency or a family member may initiate an application for a person with a developmental disability or a family member but must obtain the consent of the person or guardian to proceed with the application.

(b) Application form

(1) Department will adopt an application form to be completed by or on behalf of all applicants. The DA must provide a copy of the application to all people who contact the DA saying they wish to apply for services.

(2) Copies of the application form will be available from the Department, on the Department's website, and from every office of a DA. A person may request an application form in person, by mail, by electronic format, by facsimile (FAX), or by telephone.

(3) The DA must provide assistance to an applicant who needs or wants help to complete the application form.

(c) Where to apply

(1) An application must be filed at an office of the DA for the geographic area where the person with a developmental disability lives.

(2) An application for a person, who is new to services, who is incarcerated or living in a residential school, facility or hospital must be filed at an office of the DA for the geographic area where the person was living before going to the school, facility or hospital. For individuals who were receiving

services just prior to being in one of these facilities, an application must be filed at the DA which was last responsible prior to the individual entering the facility.

(3) An application for a person who is in the custody of the Department for Children and Families (DCF) must be filed at an office of the DA for the region in which the individual was placed in DCF custody. Applications for children under 18 who are in the custody of their parents should be filed at the DA where a custodial parent lives.

(4) An application may be submitted by mail, facsimile (FAX), secure electronic format, or in person.

(d) Screening

(1) Within five (5) business days of receiving an application, the DA must complete the application screening process. If there are extenuating circumstances that prevent completion in five (5) business days, the agency must document those in the individual's record. The screening process includes all of these steps:

(A) Explaining to the applicant the application process, potential service options, how long the process takes, how and when the applicant is notified of the decision, and the rights of applicants, including the right to appeal decisions made in the application process;

(B) Notifying the applicant of the rights of recipients in plain language, including the procedures for filing a grievance or appeal and their rights as outlined in the federal CMS HCBS rules;

(C) Discussing options for information and referral; and

(D) Determining whether the person with a developmental disability or the person's family is in crisis or will be in crisis within 60 days. If the DA determines that the person or family is facing an immediate crisis, the DA must make a temporary or expedited decision on the application.

(2) At the point of initial contact with an applicant, the DA must inform the applicant of all certified providers in the region and the options to:

(A) Receive services and supports through any certified provider in the region,

(B) Share the management of those services with the DA or SSA, or

(C) Self/family-manage their services through the Supportive ISO.

(3) Contact and referral information for options for services outside of the DA must be provided to each applicant and referral assistance provided to ensure the applicant is informed of his or her choice of all the service options listed in 7.100.5(d)(2). The DA must have documentation that the applicant was informed of all of these options.

(4) If the applicant wants more information about options or chooses to pursue services outside the DA, then the DA must contact the SSA or Supportive ISO on behalf of the applicant.

(e) Assessment

(1) The DA is responsible for conducting the assessment or assuring that it is conducted. The assessment process must involve consultation with the applicant, and, with the consent of the applicant, other organizations which support the applicant.

(2) The DA must offer information and referral to the applicant at any time that it may be helpful.

(3) Assessment consists of in-depth information-gathering to answer the four following questions:

(A) Is this a person with a developmental disability, as defined in 7.100.2(o) of these regulations, and a person eligible to be a recipient, as defined in 7.100.4? If so,

(B) What does the person or his or her family need? This question is answered through a uniform needs assessment and process approved by the Department, which determines with each person or family their service or support needs, including identification of existing supports and family and community resources.

(C) Does the situation of the person or family meet the criteria for receiving any services or funding defined as a funding priority in the *System of Care Plan*? If so,

(D) What are the financial resources of the person with a developmental disability and his or her family to pay for some or all of the services?

(f) Authorization of funding for services

Based on the answers to the questions in 7.100.5 (e), the DA will seek or authorize funding for services to meet identified needs or will determine that the individual is not eligible for the requested funding for services. The procedures for authorizing funding or services are described in the *System of Care Plan.* Services and the funding amount authorized must be based upon the most cost-effective method of meeting an individual's assessed needs, the eligibility criteria listed in the *System of Care Plan*, as well as guidance in the *System of Care Plan* and current *Medicaid Manual for Developmental Disabilities Services.* When determining cost effectiveness, consideration will be given to circumstances in which less expensive service methods have proven to be unsuccessful or there is compelling evidence that other methods would be unsuccessful.

(g) Available Programs and Funding Sources

The Department's programs reflect its current priorities for providing services for Vermont residents with developmental disabilities. The availability of the Department's current programs is subject to the limits of the funding appropriated by the Legislature on an annual basis. The nature, extent, allocation and timing of services are addressed in the *System of Care Plan (*SOCP) as specified in the DD Act. Additional details, eligibility criteria, limitations and requirements for each program are included in the SOCP, the current *Medicaid Manual for Developmental Disabilities Services,* and in specific Division guidelines. Programs will be continued, and new programs will be developed, based on annual demographic data obtained regarding Vermont residents with developmental disabilities, the use of existing services and programs, the identification of the unmet needs in Vermont communities and for individual residents of Vermont, and the reasons for any gaps in service.

(h) Special Initiatives

The Division may invest in initiatives that enhance the overall system of support for people with

developmental disabilities and their families. The Division may use funding to support initiatives that will enhance choice and control and increase opportunities for individuals receiving developmental disabilities services and their families. The timing and amount of funding for any initiative will be identified in the *System of Care Plan*. For all special initiatives, specific outcome measures will be required, and results will be reported by DDSD.

(i) Notification of decision on application

(1) Timing of the notices

(A) Within 45 days of the date of the application, the DA must notify the applicant in writing of the results of the assessment and the amount of funding, if any, which the applicant will receive.

(B) If the assessment and authorization of funding is not going to be completed within 45 days of the date of application, the DA must notify the applicant in writing of the estimated date of completion of the assessment and authorization of services or funding. A pattern of failure to complete the process within 45 days will be considered in determining whether to continue the designation of an agency.

(2) Content of notices

(A) If some or all of the services requested by the applicant are denied, or the applicant is found not eligible, the written notice must include the right to appeal the decision, the procedures for doing so, and the content of notices as specified in 7.100.9 and 8.100). Denials of eligibility must follow the procedures outlined in Health Benefit Eligibility and Enrollment Rules (HBEE) 68.00. If a decision constitutes an adverse benefit determination, including a denial of a requested service, a reduction, suspension, or termination of a service, or a denial, in whole or in part, of payment for a service, HCAR 8.100 must be followed regarding the timing and content of those notices.

(B) If the assessment determines the applicant has a developmental disability and has needs that fit within the funding priorities outlined in the *System of Care Plan*, the notice must state the amount of funding and services the applicant will receive. The notice must also state what costs, if any, the recipient is responsible to pay (7.100.7).

(C) If the assessment determines the applicant does not have a developmental disability, the notice must state that the DA will continue to offer information and referral services to the applicant.

(D) If the assessment determines the person has a developmental disability but does not meet a funding priority to receive Home and Community-Based Services funding, the notice must state that the DA will continue to offer information and referral services and will place the person's name on a waiting list (7.100.5 (q)).

(j) Choice of provider

(1) The DA must help a recipient learn about service options, including the option of self/family-managed services.

(A) It is the DA's responsibility to ensure the individual is informed of his or her choice of all services options listed in 7.100.5(d)(2), so that the individual can make an informed decision

when choosing between and among management options/service providers. The DA must document options discussed and information shared as part of this process. The DA must provide the choices in an unbiased manner to reduce the potential for conflict of interest.

(B) If the recipient is not self/family-managing services, the DA will ensure that at least one provider within the geographic area offers the authorized services at or below the amount of funding authorized at the DA.

(C) If no other provider is available to provide the authorized services and the recipient or family does not wish to self/family-manage services, the DA must provide the authorized services in accordance with its Provider Agreement.

(D) The recipient or family may receive services from any willing agency in the state.

(E) A recipient or family may request that an agency sub-contract with a non-agency provider to provide some or all of the authorized services; however, the decision to do so is at the discretion of the agency.

(2) If the recipient's needs are so specialized that no provider in the geographic area can provide the authorized services, the DA may, with the consent of the recipient, contract with a provider outside the geographic region to provide some or all of the authorized services.

(3) The recipient may choose to receive services from an agency other than the DA if the agency agrees to provide the authorized services at or below the amount of funding authorized for the DA to provide services.

(A) When requesting new funding, if an individual chooses to receive services from an agency other than the DA, or an agency agrees to subcontract with a provider, the provider will submit a budget to the DA and the DA will determine its costs to serve the individual and must submit the lower of the two budgets to the funding committee. If an alternative provider is not able to provide the services at the lower approved budget, the DA must do so at the amount of funding authorized for the DA to provide services.

(B) If at any time a recipient chooses or consents to receive some or all authorized services or supports from a different agency, the agency currently serving the recipient must promptly transfer the individual's authorized funding limit to the agency selected according to the procedures outlined in Division guidelines.

(C) When an individual chooses to transfer to another agency or to self/family-manage, the receiving agency or Supportive ISO must fully inform the recipient and the individual's authorized representative, if applicable, prior to the transfer, of the impact on the amount of services that can be provided within the approved budget based upon the agency or Supportive ISO's costs for services.

(D) Any disputes about the amount of funding to be transferred will be resolved by the director of the Division.

(4) The recipient may choose to self/family-manage services (See 7.100.6).

(k) Individual support agreement (ISA)

(1) Once a recipient has received written authorization of services or funding (7.100.5 (f)), the recipient, together with the agency or Supportive ISO, writes an ISA that defines the services and supports to be provided. The recipient may ask any person to support him or her in establishing a person-centered process, making decisions, and choosing services, supports and/or providers.

(2) The agency or, in the case of self/family-managed services, the Supportive ISO, has ultimate responsibility to ensure that an initial ISA is developed within thirty (30) days of the first day of billable services/supports or authorized start date for HCBS. This timeline may be extended at the request of the recipient, as specified in the *ISA Guidelines*.

(3) Initial and ongoing ISAs must be written and reviewed in accordance with the Department's *ISA Guidelines*. A written ISA is required even if the recipient chooses to self/family-manage services.

(4) The ISA is a contract between the recipient and provider(s) who provides the service or support.

(5) An ISA may be revised at any time.

(l) Periodic review of needs

(1) The needs of each individual currently receiving services must be re-assessed annually by the agency or Supportive ISO, together with the individual and his or her team, using the needs assessment to assure the individual's budget reflects current needs, strengths and progress toward personal goals. An Annual Periodic Review will take place as part of the planning for the individual's next ISA or ISA review. This will include an examination of the utilization of services in the past year as compared to the authorized funding limit. The individual's budget must be adjusted to reflect current needs.

(2) The agency or Supportive ISO must make adjustments in a recipient's budget and/or services, if indicated, based upon the following:

(A) Changes in the recipient's needs;

(B) Changes in use of funded services;

(C) Changes in the cost of services to meet the needs;

(D) Changes in the *System of Care Plan* or these regulations; or

(E) Changes in funds available due to insufficient or reduced appropriation or an administrative arithmetic error.

(3) As part of the periodic review, the agency or Supportive ISO must ask each recipient about his or her satisfaction with services and provide each recipient and individual's authorized representative with an explanation of the rights of recipients, including those outlined in the federal CMS HCBS rules, and how to initiate a grievance or appeal (See 7.100.9 and 8.100).

(4) If a periodic review results in a determination that services or funding should be reduced, changed, suspended or terminated, the agency or Supportive ISO must notify the recipient as provided in Section 7.100.5 (p)and Part 7.100.9 and 8.100.

(m) Full reassessment of a young child

(1) The agency or Supportive ISO must conduct or arrange for a full clinical reassessment of a child

at the time he or she turns six to determine whether the child is a person with a developmental disability. Assessments conducted by schools or other organizations should be used whenever possible to avoid duplication.

(2) *Exception:* A child receiving limited services as the result of a diagnosis of autism spectrum disorder does not need to be reassessed to confirm the diagnosis of ASD at the time he or she turns six. An adaptive behavior assessment is required at this time to confirm the child continues to have significant deficits in adaptive behavior as defined in 7.100.3.

(3) If the reassessment determines that the child is no longer a person with a developmental disability, benefits for the child and family must be phased out as provided in 7.100.5 (o)(2) of these regulations.

(n) Full reassessment (transition from high school to adulthood)

(1) The agency or Supportive ISO must conduct or arrange for a full clinical reassessment and a reassessment of needs of a recipient one year prior to his or her last month of high school. If the agency or Supportive ISO has less than one year's prior notice of the person's leaving high school, it must conduct the reassessment as soon as it learns that the person is going to leave high school or has left high school. The reassessment must consider: (A) whether the young adult is a person with a developmental disability; and (B) the future service and support needs of the person and his or her family. The needs assessment should be reviewed and updated prior to requesting funding if there have been significant changes in circumstances that impact services and supports needed. Any assessments conducted by schools or other organizations should be used whenever possible to avoid duplication.

(2) If the reassessment determines that the young adult is no longer a person with a developmental disability, services to the young adult and his or her family must be phased out as provided in 7.100.5(o)(2) of these regulations.

(3) If the reassessment determines that the support needs of the person or family will change or increase when the young adult is no longer in school, the ISA and budget must be reviewed in accordance with this section.

(o) Full reassessment

(1) The agency or Supportive ISO must conduct or arrange for full clinical reassessment of an adult or child if there is reason to believe the person may no longer have substantial deficits in adaptive behavior or may no longer have a developmental disability.

(2) If the reassessment determines that the individual is no longer a person with a developmental disability, services to the person must be phased out within twelve months or less, unless the individual is eligible to continue to receive services based on 7.100.4 (d). Upon the determination of ineligibility, the agency or Supportive ISO must provide timely notice of the decision to the recipient and the individual's authorized representative, if applicable, and as provided for in 7.100.5 (p), 7.100.9, and 8.100.

(p) Notification of results of reassessment or periodic review

If a reassessment or review results in a determination that the recipient is no longer eligible, or services should be reduced, suspended, or terminated, the agency or Supportive ISO must notify the recipient and individual's authorized representative, if applicable, in writing of the results of the review or reassessment, and of the right to appeal the decision and the procedures for doing so. The notice will include the content as specified in 7.100.9 and 8.100. Denials of eligibility should follow the procedures outlined in Health Benefit Eligibility and Enrollment Rules (HBEE) 68.00. If a decision constitutes an adverse benefit determination, including a denial of a requested service, a

reduction, suspension, or termination of a service, or a denial, in whole or in part, of payment for a service, HCAR 8.100 would be followed regarding the timing and content of those notices.

(q) Waiting list

A person with a developmental disability whose application for Home and Community-Based Services, Flexible Family Funding or Family Managed Respite is denied must be added to a waiting list maintained by the Designated Agency. The Designated Agency must notify an applicant that his or her name has been added to the waiting list and explain the rules for periodic review of the needs of people on the waiting list.

(1) The Division will provide instructions to the Designated Agency for reporting waiting list information to the Division.

(2) Each Designated Agency must notify individuals when they have been placed on a waiting list and review needs of all individuals on the waiting list, as indicated below, to see if the individual meets a funding priority, and if so, to submit a funding proposal and/or refer the individual to other resources and services. A review of the needs of all individuals on the waiting list must occur:

(A) When there are changes in the funding priorities or funds available; or

(B) When notified of significant changes in the individual's life situation.

(3) Waiting list information will be included the DDS Annual Report and will be reviewed annually by the DDS State Program Standing Committee.

7.100.6 Self/Family-Managed Services

Many individuals receiving services, or a family member of an individual receiving services, may be eligible to manage the services instead of having the services managed by an agency. Individuals may manage their services either independently or with the help of their families. An individual or a family member may manage up to 12 hours a day of In-home Family Supports or Supervised Living, but may not self/family manage Staffed Living, Group Living or Shared Living.

Self/family-management is a service option that is designed to provide choice and control to an individual or family. Self/family-management requires individuals or their family members to hire and oversee their own employees and function as the employer of record. Except for supportive services, clinical services provided by licensed professionals, or camps that provide respite, individuals and families may not purchase services from a non-certified entity or organization.

In order to self/family-manage services, the individual or family member must be capable of fulfilling the responsibilities set forth in 7.100.6(b). A Supportive ISO, in making this determination, must consider the reasons set forth in 7.100.6(f)(2), as well as any and all criteria established by the Department. An individual or a family member also has the option of managing *some, but not all,* of the services and have an agency manage some of them. This arrangement is called shared-managing. 7.100.6(g) explains how shared-managing works.

(a) Self/Family-Management Agreement

An individual or family member who is allowed to manage services must sign an agreement with a Supportive ISO. The Department will provide an approval form for agreements. The agreement must set out the responsibilities of the individual or family member and the responsibilities of the Supportive ISO.

(b) Responsibilities of an individual or family member who manages services

An individual or family member who manages services must be capable of and carry out the following functions:

(1) Maintain Medicaid eligibility for the individual receiving services. Immediately notify the Supportive ISO of any circumstances that affect Medicaid eligibility.

(2) Develop an ISA that reflects what services the individual needs and how much money the individual has been provided in their budget to spend for those services. Follow the Department's *ISA Guidelines* to ensure that all required information is included and completed according to specified timelines. The plan must specify what each service is supposed to be and how much each service will cost on an annual basis. The ISA must also identify the individual's service provider(s) and explain how the services received must be documented.

(3) Ensure that services and supports are provided to the individual in accordance with the ISA and the budget.

(4) Maintain a complete and up-to-date case record that reflects details regarding the delivery of services. Follow the *Guide to Self/Family Management* regarding what needs to be included in the case record. Retain case records in accordance with the record retention schedule adopted by the Department.

(5) Follow the rules regarding all services and supports. Those rules are called the Department's *Quality Standards for Services*. They are set forth in 7.100.11(e).

(6) Understand the individual's ISA and their budget. Make necessary changes based on the individual's needs. Follow these regulations and the Department's *ISA Guidelines* regarding what to do when there is a change.

(7) Follow the Department's *Health and Wellness Guidelines* to take care of the individual's health and safety.

(8) Follow the rules about reporting critical incidents to the Supportive ISO. Make sure the reports are filed in accordance with the specific timeline required by the Department's *Critical Incident Reporting Guidelines*.

(9) Make a report to DCF any time abuse or neglect of a child is suspected to have occurred or is occurring. Make a report to APS any time abuse, neglect, or exploitation of a vulnerable adult is suspected to have occurred or is occurring. File the reports in accordance with the specific timeframes required by law.

(10) Provide behavior supports to the individual in accordance with the Department's *Behavior Support Guidelines*. Ensure that all strategies used by workers paid to provide supports are consistent with these guidelines.

(11) Prepare written back-up plans for when the plan cannot be followed (e.g., a worker gets sick and/or does not show up for work). Include in the plan who will come and work and what will

happen if there is an emergency. It is the individual's or family member's responsibility to find workers or back-up if the plan cannot be followed. It is not the responsibility of a Supportive ISO or an agency to ensure staffing.

(12) Take part in the Department's quality review process and fiscal audits according to the procedures for these reviews. Make any changes that the Department indicates need to be made after it does a quality review or audit. Participate in Department-sponsored surveys regarding services.

(13) Take the following steps when hiring workers:

(A) Write a job description. Complete reference checks before allowing the worker to start work;

(B) Interview and hire workers that meet the requirements of the Department's Background Check Policy, or who receive a variance when there is an issue with the background check;

(C) Sign up with the state contracted F/EA. Give the F/EA all requested information to complete the background checks, carry out payroll and tax responsibilities, and report financial and service data to the Supportive ISO;

(D) Train or have someone else train all workers in accordance with these regulations. The rules are in the Department's pre-service and in-service standards in 7.100.10;

(E) Supervise and monitor workers to make sure they provide the services and supports they are hired to provide. Confirm the accuracy of workers' timesheets to verify they reflect the actual hours worked. Sign and send accurate timesheets to the F/EA;

(F) Suspend or fire workers as necessary; and

(G) Follow all Department of Labor rules required of employers, including paying overtime as required.

(14) Manage services in accordance with the Department's *Guide to Self/Family Management*.

(15) Only submit requests for payment of non-payroll goods and services that are allowed by these regulations, the *System of Care Plan* or current *Medicaid Manual for Developmental Disabilities Services*. Seek guidance from the Supportive ISO for assistance in determining what expenses are reimbursable. Ensure that requests for payment of non-payroll goods and services are accurate and consistent with goods and services received.

(c) Role of the Designated Agency

For existing recipients who are self/family managing who have a new need as determined by a new needs assessment and need an increase in services and funding, the Supportive ISO develops and submits proposals to the Supportive ISO funding committee and then to the appropriate statewide funding committee. For complex situations, the Supportive ISO may consult with an independent evaluator, the Division or the local DA to determine strategies regarding how an individual's needs may best be met. This may include a collaborative effort between the Supportive ISO and DA regarding assessments and funding proposals as needed.

(d) Role of Qualified Developmental Disability Professional (QDDP)

(1) An individual or family member who manages services must choose someone to be his or her independent QDDP or must ask the Supportive ISO to find a QDDP for him or her.

(2) All QDDP's must meet the criteria specified in the Division's *Vermont Qualified Developmental Disabilities Professional Protocol.* For QDDPs employed by an agency, the agency is responsible for ensuring that the QDDP meets those criteria. QDDPs not employed by an agency, including those working for the Supportive ISO, must be endorsed by the Department as an independent QDDP, before being paid as a QDDP.

(3) The QDDP must:

(A) Approve the individual's ISA and ensure that it is signed by the individual and guardian, if there is one;

(B) Confirm that the ISA is being carried out the way it is supposed to be and that it meets the needs of the individual;

(C) Confirm that services and supports are delivered the way the Department and Medicaid regulations and guidelines require;

(D) Contribute to the periodic review of the individual's needs conducted by the Supportive ISO;

(E) Confirm the ISA is updated to show the changes in the individual's needs and goals;

(F) Approve any changes to the ISA;

(G) Inform the individual about his or her rights as outlined in the Developmental Disabilities Act of 1996 and the rights outlined in the federal CMS HCBS rules; and

(H) Review and sign off on all critical incident reports according to the *Critical Incident Reporting Guidelines.*

(e) Responsibilities of a Supportive ISO when an individual or family member manages services

When an individual or family member manages services, the Supportive ISO must:

(1) Provide support and assistance to the individual or family member to ensure he or she understands the responsibilities of managed services including following all policies and guidelines for the Division. Explain managed services and the individual's or family member's employer role and responsibilities;

(2) Conduct periodic reviews with contributions from the QDDP, make adjustments to budgets as needed and notify the individual of his or her rights under these regulations;

(3) Confirm the individual's Medicaid eligibility on an annual basis;

(4) Help the individual or family member to develop an authorized funding limit (AFL), provide guidance in self-managing the AFL, ensure the AFL is not managed by a third party, as well as provide assistance in determining whether a service is reimbursable under Department rules.

Provide the F/EA with the individual's AFL;

(5) Bill Medicaid according to the procedures outlined in the provider agreement between the Supportive ISO and the Department;

(6) Review requests for more money and seek funding according to the process outlined in 7.100.5 of these regulations and the *System of Care Plan*. Requests for short term increases in funding will be addressed internally by the Supportive ISO. Requests for long term increases will be sent to the appropriate statewide funding committee;

(7) Confirm that the individual has a current ISA that reflects the areas of support funded in the budget and identifies and addresses any known health and safety concerns; Nofify the individual/family that funding may need to be suspended if there is not a current signed ISA, according to the timelines outlined in the ISA guidelines;

(8) Provide QDDP services when requested. QDDP services are a separately purchased service;

(9) Maintain a minimum case record in accordance with the requirements outlined in the *Guide to Self/Family Management*. Make sure that the individual or family member responsible for managing services understands that the individual must have a complete case record in accordance with the requirements outlined in the *Guide to Self/Family Management*. Retain case records in accordance with the record retention schedule adopted by the Department;

(10) Review and appropriately manage all reported critical incidents. If applicable, report the critical incidents to the Department in accordance with requirements in the *Critical Incident Reporting Guidelines*;

(11) Provide information about the Division's crisis network to the individual or family member responsible for managing services;

(12) Determine that the individual or family member who is managing the services is capable of carrying out the duties by conducting an initial assessment and providing ongoing monitoring;

(13) Provide required pre-service and in-service training to the individual's support workers if the individual or family member does not provide that training. The training requirements are located in Part 7.100.10 of these regulations; and

(14) Form and consult with an advisory committee.

(f) Determination that the individual or family member is unable to manage services

(1) The Supportive ISO may deny a request to self- or family-manage, or may terminate the management agreement, if it decides that the individual or family member is not capable of carrying out the functions listed in 7.100.6(b). If the individual's or family member's request is denied, or a management agreement is terminated, then the individual's services must be provided by the individual's DA or from a SSA willing to provide services. Unless it is an emergency, the Supportive ISO has to inform the individual or family member at least thirty (30) days before terminating the agreement.

(2) The Supportive ISO may decide that the individual or family member is not capable of carrying out the functions listed in 7.100.6(b) for reasons which include the following:

(A) The managed services put the individual's health or safety at risk (the agreement can be terminated immediately if the individual is in imminent danger);

(B) The individual or family member is not able to consistently arrange or provide the necessary services;

(C) The individual or family member refuses to participate in the Division's quality assurance reviews; or

(D) Even after receiving training and support, the individual or family member is not substantially or consistently performing his or her responsibilities for self/family-management as outlined in Section 7.100.6 (b). This includes not following policies, regulations, guidelines, or funding requirements or not maintaining and/or ensuring proper documentation for developmental disabilities services. The Supportive ISO must document substantial non-performance as follows:

(i) When the Supportive ISO discovers an issue, they must notify the individual or family member in writing of the issue and what is needed to correct the issue along with a timeline to do so; and offer support and training to the individual or family member as needed;

(ii) If the individual or family member has not corrected the issue according to the required timeframe, the Supportive ISO must send written notice to the individual or family member indicating that if the issues are not corrected in 30 days, the agreement for self/family-management may be terminated.

(iii) Repeated documented failures to follow requirements will be evidence to justify termination of the self/family-management agreement.

(3) If the Supportive ISO decides an individual or family member is not able to manage services, the individual or family member may file a request for a fair hearing with the Human Services Board, as provided in 3 V.S.A. § 3091. The Supportive ISO must provide written notice to the individual or family member at least 30 days prior to terminating a self/family-management agreement and the Supportive ISO's notice must include the individual or family member's right to request a fair hearing within 30 days of the date of the notice.

(g) Responsibilities of an individual or family member who share-manages services

An individual or family member may manage some services and let an agency manage some services. That is called shared-managing. The agency is responsible for providing information and guidance to the individual or family member regarding his or her responsibilities for share-management. An individual or family member who share-manages with an agency must do all of the following:

(1) Ensure services and supports are provided to the individual in accordance with the ISA and his or her budget.

(2) Follow the rules regarding all services and supports. Those rules are called the Department's *Quality Standards for Services*. They are in 7.100.11(e).

(3) Make and keep all papers and records as required by the agency.

(4) Report critical incidents to the agency. Make sure the reports are filed in accordance with the specific timelines required by the Department's *Critical Incident Reporting Guidelines*.

(5) Make a report to DCF any time abuse or neglect of a child is suspected to have occurred or is occurring. Make a report to APS any time abuse, neglect, or exploitation of a vulnerable adult is suspected to have occurred or is occurring. File the reports in accordance with the specific timeframes required by law.

(6) Provide behavior supports to the individual in accordance with the Department's *Behavior Support Guidelines*. Ensure that all strategies used by workers paid to provide supports are consistent with these guidelines.

(7) Prepare written back-up plans for when the plan cannot be followed (e.g., the worker gets sick and/or does not show up for work). Include in the plan who will come and work and what will happen if there is an emergency. It is the individual's or family member's responsibility to find workers or back-up if the plan cannot be followed. It is not the responsibility of a Supportive ISO or an agency to ensure staffing.

(8) Take part in the Department's quality review process and fiscal audits according to the procedures for these reviews. Make any changes that the Department indicates need to be made after it does a quality review or audit. Participate in Department-sponsored surveys regarding services.

(9) Take the following steps when hiring workers:

(A) Write a job description. Complete reference checks before allowing the worker to start work;

(B) Interview and hire workers that meet the requirement of the Department's Background Check Policy, or upon receipt of a variance when there is an issue with the background check;

(C) Sign up with the state contracted F/EA. Give the F/EA all requested information to complete the background checks, carry out payroll and tax responsibilities, and report financial and service data to the Supportive ISO;

(D) Train or have someone else train all workers in accordance with these regulations. See the Department's pre-service and in-service standards in 7.100.10;

(E) Supervise and monitor workers to make sure they provide the services and supports they are hired to provide. Confirm the accuracy of workers' timesheets. Sign and send accurate timesheets to the F/EA;

(F) Suspend or fire workers as necessary; and

(G) Follow all Department of Labor rules required of employers, including paying overtime as required.

(10) Only submit requests for payment of non-payroll goods and services that are allowed by these regulations, the *System of Care Plan* or current *Medicaid Manual for Developmental Disabilities Services*. Seek guidance from the agency for assistance in determining what are reimbursable

expenses. Ensure that requests for payment of non-payroll goods and services are accurate and consistent with goods and services received.

7.100.7 Recipient Financial Requirements

(a) Income and resources; Medicaid-funded programs

For all supports and services funded by Medicaid, the income and resource rules of Department of Vermont Health Access (DVHA) governing eligibility for Medicaid programs apply and are incorporated here by reference.

(b) Room and board; personal spending money

Medicaid developmental disabilities funding does not cover room and board, clothing, or personal effects.

(1) At least annually, the Commissioner or the Commissioner's designee will publish a schedule of rates for room and board and rates for personal spending allowances for recipients. The personal spending allowance will not be less, and may be more, than the personal spending allowance for nursing home residents. The sum of the room and board rates and the personal spending allowance will be equal to the current Supplemental Security Income (SSI) rates, including state supplement.

(2) Payment of the rate set by the Commissioner's schedule will be considered payment in full for the recipient's room and board if the recipient receives residential services funded by the Department. Recipients who receive income from a source other than SSI will be charged the same rate for room and board as SSI recipients.

(3) In unusual circumstances the Division Director may permit non-Medicaid funds of the Department to be used to subsidize the excess costs of a recipient's room and board.

(4) Recipients who rent or own their own home or apartment and have room and board costs in excess of the Commissioner's schedule will receive assistance in accessing rent subsidy, low interest loans, fuel assistance, and other sources of housing assistance for low-income Vermonters. To the extent authorized by the *System of Care Plan*, the Commissioner may provide non-Medicaid funds to subsidize the excess costs of a recipient's rent or house payment, if the recipient is unable to afford the cost.

(5) Recipients who rent or own their own home or apartment and who work may elect to use their earnings to pay rent or mortgage or room and board costs in excess of the Commissioner's schedule.

(6) The recipient, in consultation with his or her representative payee, if any, will determine how to spend the personal spending allowance.

(c) Financial responsibility of parents

The parents of a child under age 18 with a developmental disability are financially responsible for costs not covered by any Medicaid program or funded by the Department, specifically: housing; food; clothing; non-medical transportation; personal items; and childcare necessary for a parent to work.

7.100.8 Special Care Procedures

(a) Purpose

The purpose of these regulations is to ensure that people with developmental disabilities who have specialized health care needs receive safe and competent care while living in home and community settings funded by the Department.

(b) Special Care Procedure

(1) The purpose of classifying a procedure as a "special care procedure" is to provide a system for ensuring that lay people who provide special care procedures in home or community settings have the training and monitoring they need to protect the health and safety of the people they care for. These regulations follow the Vermont State Board of Nursing Position Statement – The role of the nurse in delegating nursing interventions.

(2) Examples of special care procedures are as follows:

(A) Enteral care procedures. Procedures that involve giving medications, hydration, and/or nutrition through a gastrostomy or jejunostomy tube. Special care procedures include replacement of G and J tubes, trouble-shooting a blocked tube, care of site, checking for placement, checking for residuals, use, care and maintenance of equipment; follow up regarding dietitians' recommendations, obtaining and following up lab work, mouth care, and care of formula.

(B) Procedures to administer oxygen therapy. Use of O2 tanks, regulators, humidification, concentrators, and compressed gas. This may include need for O2 assistance through use of SaO2 monitor, use of cannulas, tubing, and masks.

(C) Procedures that require suctioning techniques. Oropharyngeal (using Yankeur), nasopharyngeal (soft flexi tube) and tracheal components, which may include suctioning; clean versus sterile suctioning, care and maintenance of equipment, including stationary and portable systems.

(D) Administration of respiratory treatments. Using nebulizer set-up, care and maintenance of equipment.

(E) Tracheotomy care. Including cleaning of site and replacement of trach.

(F) Procedures that include placement of suprapubic and urethral catheters, intermittent catheterization, use and care of leg bags, drainage bags, when and how to flush, clean versus sterile catheterization.

(G) Procedures that include care of colostomy or ileostomy. Care of the stoma and maintenance of equipment.

(H) Diabetes care, including medications, use of insulin, monitoring.

(c) Application and limitations

(1) These sections (7.100.8) apply to DAs and SSAs (including their staff and contractors).

(2) These sections (7.100.8) apply to managed services, but they do not apply to care provided by natural or adoptive family members unless the family member is compensated for providing the

care with funds administered or paid by the Department.

(3) These regulations do not apply to care provided by hospital or nursing home staff.

(d) Determining that a procedure is a special care procedure

The determination that a care procedure is a "special care procedure" has three components:

(1) The procedure requires specialized nursing skill or training not typically possessed by a lay individual;

(2) The procedure can be performed safely by a lay individual with appropriate training and supervision; and

(3) The individual needing the procedure is stable in the sense that outcomes are predictable.

(e) Who determines special care procedures

(1) The initial identification of the possible need for a special care procedure may be made by the agency that serves the individual, by nursing staff of the Department, or by any other health providers.

(2) A registered nurse must determine whether a procedure is a special care procedure.

(f) Who may perform a special care procedure

(1) A special care procedure may be performed only by a person over the age of 18 who receives training, demonstrates competence, and receives monitoring in accordance with these regulations.

(2) Competence in performing a special care procedure is individualized to the particular needs, risks, and characteristics of an individual. The fact that an employee or contractor may have been approved to perform a special care procedure for one individual does not create or imply approval for that person to perform a similar procedure for another individual.

(3) The agency responsible for the health needs of the individual must ensure that special care procedures are performed by lay people trained in accordance with the regulations, or by a qualified health professional.

(4) The agency is responsible for having a back-up plan for situations where the person or people trained to perform a special care procedure for an individual are unavailable. If a trained lay person is not available, the procedures must be performed by a qualified health professional. In the case of managed services, the services coordinator bears responsibility for having a back-up plan.

(g) Specialized care plan

(1) If a nurse has determined that an individual needs a special care procedure, the agency is responsible for ensuring that a specialized care plan is attached to the ISA and that every person who is authorized to perform a special care procedure has a copy of the specialized care plan.

(2) A registered nurse must complete an assessment of the person prior to developing the specialized care plan. The specialized care plan must be developed by the registered nurse and must identify the specialized care procedures and the nurse responsible for providing training,

determining competence, and reviewing competence. The specialized care plan must also include a schedule for the nurse to monitor the performance of specialized care procedures. (7.100.8(j)).

(h) Training

(1) Qualifications of trainer. Training must be provided by a nurse. The nurse must have a valid State of Vermont nursing license.

(2) Timeliness. Training must be provided before any caregiver who is not a health professional provides a special care procedure without supervision. Training must be provided in a timely manner so as not to impede services for an individual.

(3) Best practice. Training in special care procedures must conform to established best practice for performance of the procedure.

(4) Individual accommodations. Individuals with developmental disabilities have had unique experiences that may enhance or obstruct the ability to provide care. Within the framework of special care procedures, a combination of best practice and accommodation of individual characteristics will define the procedures to be used with a particular individual.

(5) Documentation of training. The agency responsible for the health needs of the individual is responsible for ensuring that the nurse provides a record of training for any person who is carrying out a special care procedure. The records must include information about who provided the training, when the training was provided, who received training, what information was provided during the training, and the conditions under which reassessment and retraining need to occur.

(6) Emergencies. The nurse must be notified of any changes in an individual's condition or care providers. The agency responsible for the health needs of the individual must ensure that special care procedures are performed by lay people trained in accordance with the regulations, or else by nursing personnel. If the nurse determines that, as a result of the emergency, a trained lay person cannot safely perform the procedure, the procedure must be performed by a qualified health professional.

(i) Competence

The determination of competence is a determination that a person demonstrates adequate knowledge to perform a task, including use of equipment and basic problem-solving skills. Competence includes capability, and adequate understanding.

(1) Determination of competence. Determination of competence must be made by a nurse. The specialized care plan must identify the nurse responsible for making this determination.

(2) Supervised practice. An individual who is working toward but has not yet achieved status of a competent special care provider must provide specialized care under the supervision of a nurse.

(3) Competence defined. Competence involves demonstrating safe performance of each step of the special care procedure and proper use and maintenance of equipment, basic problem-solving skills, consistency of performance, and sufficient theoretical understanding.

(4) Documentation of competence. The record must document which people are determined

competent to perform a special care procedure.

(5) Review of competence. A specialized care provider's competence must be reviewed by a nurse at least annually and also when that worker's competence is in question, or at any time when there is change in the condition of the individual.

(j) Monitoring

Ongoing monitoring by a nurse ensures that a special care provider's skills and knowledge continue to be current. The individual's specialized care plan must include monitoring requirements, including expectations for monitoring the performance of special care procedures and patient outcomes at least annually.

7.100.9 Internal Appeals, Grievances, Notices, and State Fair Hearings

Medicaid-funded services for eligible individuals with developmental disabilities are part of the Global Commitment to Health 1115(a) Medicaid Waiver, which is an 1115(a) Demonstration waiver program under which the Federal government waives certain Medicaid coverage and eligibility requirements found in Title 19 of the Social Security Act. As set forth in the Demonstration, the Agency of Human Services (AHS), as the state, and the Department of Vermont Health Access (DVHA), as if it were a non-risk prepaid in-patient health plan (PIHP), must comply with all aspects of 42 C.F.R. Part 438, Subpart F, regarding a grievance and internal appeal system for Medicaid beneficiaries seeking coverage for Medicaid services, including developmental disabilities services.

AHS has adopted Health Care Administrative Rule (HCAR) 8.100, which fully sets forth the responsibilities of the Vermont Medicaid Program, as required by 42 CFR Part 438, Subpart F. This rule details, among other things, the content and timing of notices of an Adverse Benefit Determination, the circumstances relating to continuing services pending appeal and potential beneficiary liability, and the State fair hearing and grievance processes.

For provisions that govern Medicaid applicant and beneficiary appeals regarding financial, non-financial, categorical, and clinical eligibility for developmental disabilities services, refer to Health Benefit Eligibility and Enrollment Rules (HBEE) Part 8 (State fair hearings/expedited eligibility appeals). HBEE Part 8 also sets forth the requirements for maintaining benefits/eligibility pending a State fair hearing. HBEE Part 7 (Section 68.00) contains the requirements for notices of an adverse action.

The Division will develop a plain language guide to the Internal Appeals, Grievances, Notices, and State Fair Hearings, in collaboration with stakeholders. The guide will be made available to all applicants and authorized representatives during the initial screening and all recipients during the annual periodic review, as well as whenever an applicant or recipient is notified of a decision regarding eligibility or service authorization. The plain language guide will include specifics related to how to file a grievance or appeal, to whom it should be directed, timelines and where to get assistance in filing.

7.100.10 Training

(a) Purpose

Training is an ongoing process that helps ensure safety and quality services and reflects the principles of services of the Developmental Disabilities Act of 1996, generally accepted best practices, and promising practices and the priorities of the *System of Care Plan* and these regulations.

(b) Standards

(1) The Division will develop training standards and periodically update them to ensure that workers:

(A) Understand the values and philosophy underlying services and supports;

(B) Acquire skills necessary to address the individual needs of the recipient for whom they provide services and support;

(C) Acquire skills to implement the principles and purposes of the Developmental Disabilities Act of 1996; and

(D) Are exposed to best and promising practices in supporting individuals with developmental disabilities.

(2) In developing the standards, the Division will endeavor to involve individuals with developmental disabilities and their families in the design, delivery, and evaluation of training.

(3) The minimum standards for training are outlined in (c) – (f).

(c) Agency and Supportive Intermediary Support Organization responsibilities

(1) Each agency must adopt and implement a training plan which ensures adherence to the following minimum standards:

(A) Workers compensated with funds paid or administered by the agency must receive pre-service and in-service training or have knowledge and skills in the areas addressed by pre-service and in-service training consistent with Department and Division standards and these regulations.

(B) Workers, on an ongoing basis, must have opportunities to broaden and develop their skills and knowledge in the following areas:

(i) Best and promising practices;

(ii)Values including:

The principles of supporting people to have valued roles in their community including:

(1) The dignity of valued roles

(2) Sharing ordinary places

(3) Making choices and the dignity of risk

(4) Relationships in living a full life

(5) Making contributions to others

The principles of person-centered thinking including:

(1) How to respectfully address significant issues of health or

safety while supporting choice

(2) How to sort what is important for people from what is important to the people we support

(3) How rituals and routines play a role in what is important to the people we support

(4) The importance of having power with rather than power over the people we support;

(iii) Current and emerging worker responsibilities; and

(iv) Current and emerging needs of the individual.

(2) The training plan must be written and based on the agency's assessment of its ability and capacity to meet the needs of the people it serves, the local *System of Care Plan*, and the training needs of its staff and board members.

(3) The training plan must be updated as needed but at least every three years.

(4) Each agency, and Supportive ISO must:

(A) Have a system to verify that all workers compensated with funds administered or paid by the organization have received pre-service and in-service training in accordance with these regulations or have knowledge and skills in the areas addressed by pre-service and in-service training.

(B) Make pre-service and in-service training available to all workers at no cost to the family or recipient.

(C) Involve people with disabilities and their families in the design, delivery, and evaluation of training and invite them to participate in training.

(D) Have a system to verify that all workers have been told about and understand the requirement to report abuse and neglect of children to the DCF, and abuse, neglect and exploitation of vulnerable adults to APS.

(5) Each agency and Supportive ISO must:

(A) Inform each person that self/family-manages services or share-manages services about the recipients or family's responsibility for ensuring that all workers receive pre-service and in-service training in accordance with these regulations.

(B) Inform each person that self/family-manages or share-manages services about the availability of pre-service and in-service training at no cost to the family.

(d) Pre-service training

Before working alone with an individual who receives support funded by the Department, each worker must be trained and demonstrate knowledge in (1) through (5) of this section. The employer of record, whether recipient, family, shared living provider, contractor, or agency, is responsible for providing or arranging for this training for their workers. The agency or Supportive ISO is responsible for verifying that the employer of record has provided or arranged for this training.

(1) Abuse reporting requirements:

(A) The requirements of Vermont law to report suspected abuse or neglect of children; and

(B) The requirements of Vermont law to report suspected abuse, neglect, or exploitation of vulnerable adults.

(2) Health and Safety:

(A) Emergency procedures, including where to locate the emergency fact sheet;

(B) What to do if the individual is ill or injured;

(C) Critical incident reporting procedures; and

(D) How to contact a supervisor or emergency on-call staff.

(3) Individual specific information. (The provisions of this subsection apply each time a worker works with a different individual or family.)

(A) Whether the individual has a guardian, and how to contact the guardian;

(B) The individual's behavior, including the individual's specific emotional regulation support requirements and behaviors which could place the person or others at risk;

(C) Health and safety needs of the individual;

(D) Methods of communication used by the individual including tools, technology and effective partner support strategies; and

(E) The individual's ISA, including the amount of supervision the individual requires.

(4) Values:

(A) Individual rights, as specified in 18 V.S.A. § 8728 and as outlined in the federal CMS HCBS rules;

(B) Confidentiality;

(C) Respectful interactions with individuals and their families; and

(D)Principles of service contained in the Developmental Disabilities Act of 1996.

(E) Respecting that people can make decisions for themselves, with support when needed.

(F) Presumption of Competence: a strength-based approach that assumes all people have abilities to learn, think, and understand.

(5) How to access additional support, training, or information.

(e) In-service training

(1) Within three months of being hired or entering into a contract, workers must be trained in and demonstrate the knowledge and skills necessary to support individuals in 7.100.10(e)(1)(A) and (B). Workers must be trained in or demonstrate knowledge and skills necessary to support individuals, in 7.100.10(e)(1)(C) and (D). The employer of record, whether recipient, family, shared living provider, contractor, or agency, is responsible for providing or arranging for this training for their workers. The agency or Supportive ISO is responsible for verifying that the employer of record has provided or arranged for this training.

(A) The worker's role in developing and implementing the ISA, including the role and purpose of the ISA, and working as part of a support team;

(B) The skills necessary to implement the recipient's ISA (including facilitating inclusion, teaching and supporting new skills, being an effective communication partner to support methods of communication used by the recipient, and supporting decision making). For self/family-managed services, the employer of record is responsible for providing or arranging for this training for their workers. For share-managed services and respite, the agency is responsible to ensure the employer of record has provided the training and the worker demonstrates knowledge in the areas trained;

(C) Vermont's developmental disabilities service system (including Department policies and procedures) and agency policies and procedures as relevant to their position in order to carry out their duties; and

(D) Basic first aid.

(2) Workers must be trained in blood-borne pathogens and universal precautions within time frames required by state and federal law.

(f) Exception for emergencies

(1) For the purposes of this section, "emergency" means an extraordinary and unanticipated situation of fewer than 72 consecutive hours.

(2) In an emergency, if the unavailability of a trained worker creates a health or safety risk for the individual, a worker who has not received pre-service training or demonstrated knowledge in all pre-service areas may be used for up to 72 hours after the worker first begins to work with the individual in response to the emergency, as long as essential information about the individual is communicated to the worker and he or she has immediate access to all the documents and information covering all areas of Pre-service training (see 7.100.10 (d)).

(3) This exception does not apply to workers performing special care procedures. All requirements in 7.100.8 of these regulations must be met prior to staff performing special care procedures.

7.100.11 Certification of Providers

(a) Purpose of certification

In order to receive funds administered by the Department to provide services or supports to people with developmental disabilities, providers must be certified to enable the Department to ensure that an agency can meet certain standards of quality and practice.

(b) Certification status

(1) To meet certification standards, an agency must:

(A) Meet the standards for designation as a DA or SSA (see *Administrative Rules on Agency Designation*);

(B) Meet the Department's *Quality Standards for Services* (7.100.11(e)); and

(C) Provide services and supports that foster and adhere to the Principles of Service (See 18 V.S.A. §8724) and the Rights guaranteed by the Developmental Disabilities Services Act (See 18 V.S.A. §8728) and the rights outlined in the federal CMS HCBS rules.

(2) Current providers. Any agency receiving Department funds on the effective date of these regulations is presumed to be certified.

(3) New provider. A new provider that wishes to be certified by the Department must first establish that it meets the standards for designation. Upon being designated, an organization must apply in writing to the Department for certification. The application must include policies, procedures, and other documentation demonstrating that the organization is able to meet the quality standards for certification contained in 7.100.11(e) and provide services and supports that foster and adhere to the Principles of Service (See 18 V.S.A. §8724) and the Rights guaranteed by the Developmental Disabilities Services Act (See 18 V.S.A. §8728).

(4) Providers that are not designated will not be certified.

(5) If a certified provider loses its designation status, the provider is automatically de-certified.

(6) The Department will send the applicant a written determination within 30 days after receiving an application for certification. In order to receive funds administered by the Department, an organization must be certified and have a Provider Agreement with the Department.

(c) Monitoring of certification

The Department will monitor certified providers through a variety of methods including quality reviews, other on-site visits, review of critical incident reports and mortality reviews, investigation of complaints from recipients and the public, input from Department staff and staff or employees of other departments of AHS.

(d) Services available regardless of funding source

(1) Any services or supports which are provided to people who are eligible for Medicaid must be made available on the same basis to people who are able to pay for the services or who have other sources of payment.

(2) The rate charged to recipients who are able to pay for services or who have payment sources other than Medicaid must be the same as the rate charged to Medicaid-eligible recipients, *except that* the rate may be discounted to reflect lower administrative or implementation costs, if any, for non-Medicaid recipients. If a provider establishes a sliding fee scale for such services, the provider must have a source of funding (such as United Way, state funds, donated services) for the difference between the cost of providing the service and the fee charged.

(3) Any services not funded by Medicaid may be made available in accordance with a sliding fee schedule.

(e) Quality standards for services

To be certified, an agency must provide or arrange for services that achieve the following outcomes as specified in *Guidelines for the Quality Review Process of Developmental Disabilities Services:*

(1) Respect: Individuals feel that they are treated with dignity and respect.

(2) Self Determination: Individuals direct their own lives and receive support in decision making when needed.

(3) Person Centered: Individuals' needs are met, and their strengths and preferences are honored.

(4) Independent Living: Individuals live and work as independently and interdependently as they choose.

(5) Relationships: Individuals experience positive relationships, including connections with family and their natural supports.

(6) Participation: Individuals participate in their local communities.

(7) Well-being: Individuals experience optimal health and well-being.

(8) Communication: Individuals communicate effectively with others.

(9) System Outcomes.

(f) Status of non-designated providers

(1) Any non-designated entity or organization that provides services or supports to individuals with funds administered by the Department must be a subcontractor of an agency. This requirement does not apply to persons employed as independent direct support providers. The decision to subcontract with an entity or organization is at the discretion of the agency.

(2) The Department quality service reviews will be responsible for including people served by subcontracted providers to verify that they meet quality review standards.

(3) Any subcontract must contain provision for operations in accordance with all applicable state and federal policies, rules, guidelines, and regulations that are required of agencies.

(4) Agencies must require the following through all of its subcontracts: reserve the right to conduct inquiries or investigations without prior notification in response to incidents, events or conditions that come to its attention that raise concerns as to person-specific allegations regarding safety, quality of supports, the well-being of people who receive services or any criminal action. Further, the Department may conduct audits without advanced notice.

(5) Having a subcontract does not terminate an agency receiving funds under Vermont's Medicaid program from its responsibility to ensure that all activities and standards under their Provider Agreement with the Department are carried out by their subcontractors.

7.100.12 Evaluation and Assessment of the Success of Programs

The Department will evaluate and assess the success of programs using the following processes:

(1) The review of services provision, as outlined in the *Guidelines for Quality Review of Developmental Disabilities Services,* as well as those processes outlined in Appendix B of the quality review guidelines *Sources of Quality Assurance and Protection for Citizens with Developmental Disabilities;*

(2) The designation process for DA and SSAs as outlined in the *Administrative Rules on Agency Designation;*

(3) Review of the data reported by agencies on required performance measures and monitoring of programs, as described in the agencies' Provider Agreements with the Department; and

(4) Review of performance measures submitted to AHS, as required by 2022 Acts and Resolves No. 186.

The information gathered will be used for informing the continuation of programs, quality improvement, innovations in service delivery and policy development.

Choices for Care

7.102.1 Choices for Care Purpose and Scope (04/15/2020, GCR 19-059)

(a) The "Choices for Care" program operates within the State's Global Commitment to Health 1115 Waiver providing long-term services and supports to aging or physically disabled Vermont adults.

(b) The Choices for Care program is subject to approval by the Centers for Medicare and Medicaid Services (CMS) and is managed in compliance with CMS terms and conditions of participation.

(c) The primary goal of the Choices for Care waiver is to provide Vermonters with equal access to licensed nursing facility, licensed residential care/assisted living, or home and community-based services, consistent with their choice.

7.102.2 Definitions

For the purposes of this rule, the term:

(a) **"Activities of Daily Living"** (ADLs) means dressing and undressing, bathing, personal hygiene, bed mobility, toilet use, transferring, mobility in and around the home, and eating.

(b) **"Adult Day Services"** means a range of health and social services provided at a location that has been certified by DAIL.

(c) **"Adult Family Care" (AFC)**, also known as "shared living" means 24-hour care and supervision provided by an approved unlicensed home provider, limited to a maximum of two individuals in each setting, and managed by an agency authorized by DAIL.

(d) **"Applicant"** means an individual who has submitted a Choices for Care application and whose eligibility status is pending.

(e) **"Assistive Devices" means** devices used to increase, maintain, or improve the individual's functional capabilities.

(f) **"Authorized Agency"** means an agency authorized by DAIL to provide and arrange for Adult Family Care to eligible participants.

(g) **"Behavioral Symptoms"** means behavior that is severe, frequent and requires a controlled environment to provide continuous monitoring or supervision.

(h) **"Case Management"** is a home-based service that assists older adults and adults with disabilities to access the services they need to remain as independent as possible in accordance with their identified goals. Case management is a collaborative, person-centered process of assessment, identifying goals, planning and coordination of services, advocacy, options education and ongoing monitoring to meet a person's comprehensive needs, promoting quality and cost-effective outcomes. Case Management Services assist DAIL in monitoring the quality, effectiveness and efficiency of CFC services.

(i) **"Commissioner"** means the Commissioner of the Department of Disabilities, Aging and Independent Living.

(j) **"Companion/Respite"** means a home-based service that provides non-medical supervision and socialization for participants as determined by the needs of the individual, and which is limited in combination with Respite care.

(k) **"Controlled Environment"** means an environment that provides continuous care and supervision.

(l) **"DAIL"** means the Department of Disabilities, Aging and Independent Living.

(m) **"Date of Application"** means the date that an application is received by the Department of Vermont Health Access (DVHA).

(n) **"DVHA"** means the Department of Vermont Health Access.

(o) **"Eligibility Groups"** means the groups of people who are found to meet the eligibility criteria for the Highest, High, or Moderate Needs groups.

(p) **"Enhanced Residential Care"** means a 24-hour package of services provided to individuals residing in a licensed Residential Care Home, Assisted Living Residence or Home for the Terminally Ill.

(q) **"Enrolled"** means that an applicant has been found eligible, has been assigned to an eligibility group, and is authorized to receive services.

(r) **"Extensive Assistance"** means one of five levels of assistance used when assessing an applicant or participant's self-performance of Activities of Daily Living. Levels range from "Independent" to "Total" assistance. An applicant or participant is assessed as needing "Extensive Assistance" when hands on assistance or standby assistance is needed to complete the task safely within a reasonable period of time and when the assistance has been provided three or more times in the last seven days.

(s) **"Fiscal/Employer Agent (F/EA)"** means an organization that contracts with the State to provide assistance to eligible participants with payroll, taxes, and other financial management tasks for consumer or surrogate-directed self-managed home-based services.

(t) **"Flexible Choices"** means a home-based High and Highest Needs Group service option that allows an eligible consumer or surrogate employer to manage a flexible budget.

(u) **"Flexible Funds"** means a home-based Moderate Needs Group service option that provides access to a limited amount of funds that may be used to purchase needed goods or services.

(v) **"High Needs Group"** means participants who have been found to meet the High Needs Group clinical eligibility criteria and have been authorized to receive services.

(w) **"Highest Needs Group"** means participants who have been found to meet the Highest Needs Group clinical eligibility criteria and have been authorized to receive services.

(x) **"Home-Based"** means the setting in which Choices for Care services are provided to a participant who resides in their own home. This does not include a licensed facility or a formal Adult Family Care home provider. Home-based services do not cover 24-hours per day of services.

(y) **"Home and Community-Based Services"** means all long-term services and supports provided under these regulations, with the exception of those provided at licensed facilities.

(z) **"Homemaker Services"** means a home-based service that assists a participant with Instrumental Activities of Daily Living such as shopping, cleaning, and laundry provided to help people live at home in a healthy and safe environment.

(aa) **"Home Modifications"** means physical adaptations to the individual's home that help to ensure the health and welfare of the individual or that improve the individual's ability to perform ADLs, IADLs, or both.

(bb) **"Imminent Risk"** means there is a current threat or an event that will threaten an individual's personal health and/or safety within 45 days.

(cc) **"Individualized Budget"** means a dollar amount that has been authorized by DAIL for long-term services and supports to a participant who self-directs their Choices for Care services in the home-based setting.

(dd) **"Informed Consent"** means a process by which an individual or an individual's authorized representative (as defined in HCAR 8.100.2) makes choices or decisions based on an understanding of the potential consequences of the decision, free from any coercion, and fully informed about all feasible options and their potential consequences.

(ee) **"Instrumental Activities of Daily Living"** (IADLs) means meal preparation, medication management, telephone use, money management, household maintenance, housekeeping, laundry, shopping, transportation, and care of adaptive equipment.

(ff) **"Long-Term Services and Supports"** is a general term referring to services covered by the Choices for Care 1115 Medicaid Waiver as described in these regulations.

(gg) **"Moderate Needs Group"** means participants who have been found to meet the Moderate Needs Group eligibility criteria and who have been authorized to receive services.

(hh) **"Participant"** means an individual for whom services have been authorized in accordance with these regulations.

(ii) **"PASRR"** means Pre-Admission Screening and Resident Review (PASRR) that is a federally required

process (Omnibus Budget Reconciliation Act of 1987) to determine whether placement or continued stay in a nursing facility is appropriate, and to identify the specialized services an individual with mental health or intellectual disability needs, including services the nursing facility can provide and services that must be arranged separately.

(jj) **"Person-Centered Planning"** means a process supporting the participant in accordance with 42 CFR § 441.301(c)(1) that builds upon the person's capacity to engage in activities that promote community life and that honor the person's preferences, choices, and abilities and which involves families, friends, and professionals as the individual desires or requires.

(kk) **"Personal Care"** means assistance to participants with ADLs and IADLs that is essential to the individual's health and welfare.

(ll) **"Personal Emergency Response Systems (PERS)**" means electronic devices that enable participants to secure help in an emergency and provided by a vendor that has been authorized by DAIL.

(mm) **"Physically Aggressive Behavior"** means hitting, shoving, scratching, or sexual assault of other persons. The behavior must be severe and frequent, requiring a controlled environment to provide continuous monitoring or supervision.

(nn) **"Provider"** means any individual, organization, or agency that has been authorized by DAIL to provide Long-Term Services and Supports and has enrolled as a Vermont Medicaid provider.

(oo) **"Provider Qualifications"** means the requirements established by DAIL for providers of specific services, including any regulations pertaining to each provider.

(pp) **"Quality Management"** means a set of integrated tools and practices used to maximize its effectiveness, efficiency and performance, with a primary focus on participant outcomes.

(qq) **"Reimbursement"** means payment made by Vermont Medicaid to a provider for the provisions of services.

(rr) **"Resists Care"** means unwillingness or reluctance to take medications, injections or accept ADL assistance. Resisting care does not include instances where the individual has made an informed choice not to follow a course of care (e. g., individual has exercised his or her right to refuse treatment, and reacts negatively as staff try to reinstitute treatment). Resistance may be verbal or physical (e. g., verbally refusing care, pushing caregiver away, scratching caregiver).

(ss) **"Respite Care"** means relief from caregiving and supervision for primary caregivers.

(tt) **"Service Authorization"** means a communication through which services are authorized by DAIL, which guides the delivery of services and Medicaid payment.

(uu) **"Service Standards"** means the requirements established by DAIL for the delivery of specific services.

(vv) **"Significant Change"** means a change in condition or circumstances that substantially affects an individual's need for assistance including increases in functional independence, decreases in functional independence, and a change in other services or support provided by family and friends.

(ww) **"Total Assistance"** means one of five levels of assistance used when assessing an applicant or participant's self-performance of Activities of Daily Living (ADL). Levels range from "Independent" to "Total" assistance. An applicant or participant is assessed as needing "Total Assistance" when totally dependent on others to complete the task safely within a reasonable period of time.

(xx) **"Variance"** means an exception to or exemption from these regulations granted by DAIL as allowed under applicable statute and regulation.

(yy) **"Verbally Aggressive Behavior"** means threatening, screaming at, or cursing people. The behavior must be severe and frequent, and because of its hostile nature, requires consistent planned behavioral interventions and approaches requiring a controlled environment to provide continuous monitoring or supervision.

(zz) **"Wandering"** means locomotion with no discernible, rational purpose by an individual who behaves as one who is oblivious to his or her physical or safety needs, and which locomotion presents a clear risk to the individual. Wandering may be manifested by walking or wheelchair. Pacing back and forth is not considered wandering.

7.102.3 General Policies

(a) Services shall be based on person-centered planning and shall be designed to ensure quality and protect the health and welfare of the individuals receiving services.

(b) Services shall be provided in a cost-effective and efficient manner, preventing duplication, unnecessary costs, and unnecessary administrative tasks.

(c) DAIL shall manage services so as to use resources efficiently and to maximize the benefits and services available to the greatest number of eligible individuals.

(d) DAIL shall administer the Choices for Care (CFC) program in accordance with these regulations, the CMS terms and conditions, and applicable state and federal law.

(e) Eligible individuals shall be informed of feasible service alternatives.

(f) DAIL encourages any applicant or participant who disagrees with a decision made by the State to contact State program staff person who made the decision to try to resolve the disagreement informally.

7.102.4 Covered Services

Choices for Care services approved for eligible participants include:

Setting	Service	Eligibility Group	Maximum
Home-Based	Adult Day	High/Highest Needs	Up to 12 hours per day
		Moderate Needs	Up to 50 hours per week
	Assistive Devices & Home Modifications	High/Highest Needs	Up to the current rate on file per calendar year
	Case Management	High/Highest Needs	Up to 48 hours per calendar year.
		Moderate Needs	Up to 24 hours per calendar year.
	Companion/Respite (agency directed)	High/Highest Needs	Up to 720 hours per calendar year
	Flexible Funds	Moderate Needs	Up to the amount of the individualized budget
	Homemaker	Moderate Needs	Up to 6 hours per week
	Personal Care (agency directed)	High/Highest Needs	Up to the amount of the participant's authorized service plan or individualized budget. IADLs shall not exceed 4.5 hours/week.
	Personal Emergency Response	High/Highest Needs	Up to the current monthly rate on file plus a one-time set-up fee
	Fiscal Employer Agent (F/EA) Services	High/Highest/Moderate Needs	Up to the rate on file as negotiated by State contract.
	Self-Directed Services: Flexible Choices, Consumer and Surrogate Directed Personal Care, Respite, Companion	High/Highest Needs	Up to the amount of the individualized budget
Adult Family Care	Case management, personal care, respite, assistive devices/home	High/Highest Needs	Up to the bundled daily tier rate on file based on

	modifications, community participation in a shared living setting.		the participant's authorized service plan
	Adult Day	High/Highest Needs	Up to 12 hours per day
Enhanced Residential Care	Bundled daily rate to cover 24-hour services in an approved Vermont licensed care home	High/Highest Needs	Up to the authorized tier rate on file
Nursing Facility	Bundled daily rate to cover 24-hour services in a facility licensed according to the 42 CFR § 483, Subpart B and Vermont regulations	High/Highest Needs	Current rate on file

Individual service standards are managed by DAIL and can be found in the Choices for Care Program Manuals and align with the 1115 Global Commitment to Health waiver Special Terms and Conditions.

Choices for Care service rates and codes may be found on the Adult Services Division website or by contacting the Vermont Medicaid fiscal agent.

7.102.5 Eligibility

(a) High/Highest Needs Group:

(1) Individuals who wish to enroll in the Choices for Care Highest or High Needs Groups shall complete an application and file it with the Vermont Medicaid.

(2) Applicants must meet clinical, financial, categorical, and non-financial (e.g. residence, citizen/immigration status, etc.) eligibility requirements based on criteria set for each eligible group.

(3) DAIL shall verify that applicants applying for Choices for Care in a nursing facility have had a PASRR completed prior to granting clinical eligibility.

(4) DAIL shall make a decision regarding clinical eligibility for Choices for Care within 30 days of receiving the application.

(5) DAIL shall review clinical eligibility once per year, at minimum, for all active participants.

(6) Clinical Eligibility:

(A) Highest Need clinical eligibility requires at least one of the following:

(i.) Extensive or total assistance with at least one of the following Activities of Daily Living (ADLs): toilet use; eating; bed mobility; or transfer and require *at least* limited assistance with any other ADL.

(ii.) Severe impairment with decision-making skills or a moderate impairment with decision-making skills and one of the following behavioral symptoms/conditions, which occurs frequently and is not easily altered:

Wandering	Verbally Aggressive Behavior
Resists Care	Physically Aggressive Behavior Behavioral Symptom

(iii.) At least one of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis:

Stage 3 or 4 Skin Ulcers	Ventilator/ Respirator
IV Medications	Naso-gastric Tube Feeding
End Stage Disease	Parenteral Feedings
2nd or 3rd Degree Burns	Suctioning

(iv.) An unstable medical condition that requires skilled nursing assessment, monitoring and care on a daily basis related to, but not limited to, at least one of the following:

Dehydration	Internal Bleeding
Aphasia	Transfusions
Vomiting	Wound Care
Quadriplegia	Aspirations
Chemotherapy	Oxygen
Septicemia	Pneumonia
Cerebral Palsy	Dialysis
Respiratory Therapy	Multiple Sclerosis
Open Lesions	Tracheotomy
Radiation Therapy	Gastric Tube Feeding

(v.) DAIL shall enroll an individual in the Highest Needs Group when it determines that the individual has a critical need for long-term care services due to special circumstances that may adversely affect the individual's safety. DAIL may, with the consent of the individual, initiate such an action. An individual may also request such an action. Special circumstances may include:

1. Loss of primary caregiver (e.g. hospitalization of spouse, death of spouse),
2. Loss of living situation (e.g. fire, flood),
3. The individual's health and welfare shall be at imminent risk if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.), or

4. The individual's health condition would be at imminent risk or worsen if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.).

(B) High Need clinical eligibility requires at least one of the following:

(i.) Individuals who require extensive-to-total assistance on a daily basis with at least one of the following ADLs:

Bathing	Dressing
Eating	Toilet Use
Physical Assistance to Walk	

(ii.) Individuals who require skilled teaching on a daily basis to regain control of, or function with at least one of, the following:

Gait Training	Speech
Range of Motion	Bowel or Bladder Training

(iii.) Individuals who have impaired judgment or impaired decision-making skills that require constant or frequent direction to perform at least one of the following:

Bathing	Dressing
Eating	Toilet Use
Transferring	Personal Hygiene

(iv.) Individuals who exhibit at least one of the following behaviors requiring a controlled environment to maintain safety for self:

Constant or Frequent Wandering Behavioral Symptoms
Physically Aggressive Behavior Verbally Aggressive Behavior

(v.) Individuals who require an aggregate of other services (personal care, nursing care, medical treatments or therapies) on a daily basis and have a condition or treatment that requires skilled nursing assessment, monitoring, and care on a less than daily basis including, but not limited to, the following:

Wound Care	Suctioning
Medication Injections	End Stage Disease
Parenteral Feedings	Severe Pain Management
Tube Feedings	

(vi.) Individuals whose health condition shall worsen if services are not provided or if services are

discontinued upon reassessment due to clinical ineligibility.

(vii.) Individuals whose health and welfare shall be at imminent risk if services are not provided or if services are discontinued upon reassessment due to clinical ineligibility.

(C) Moderate Needs Group clinical eligibility requires at least one of the following:

(i.) Individuals who require supervision or any physical assistance three or more times in seven days with any single ADL or IADL, or any combination of ADLs and IADLs.

(ii.) Individuals who have impaired judgment or decision-making skills that require general supervision on a daily basis.

(iii.) Individuals who require at least monthly monitoring for a chronic health condition.

(iv.) Participants whose health condition shall worsen if services are not provided or if services are discontinued upon reassessment due to clinical ineligibility.

(7) Financial, Non-Financial, and Categorical Eligibility

(A) High/Highest Need Group financial, non-financial, and categorical eligibility follows the Medicaid rules for Long-Term Care eligibility found in the Health Benefits, Eligibility and Enrollment (HBEE) rules on the Agency of Human Services website.

(B) Moderate Needs financial eligibility is based on self-reported income and resources.

(i.) Countable Income is all sources of income, including Social Security, SSI, retirement, pension, interest, VA benefits, wages, salaries, earnings and rental income, whether earned or unearned. The income standard for the Moderate Needs Group is met if the adjusted monthly income of the individual (and spouse, if any) is less than 300% of the Vermont supplemental security income (SSI) payment standard for one person (or couple) in the community after deducting recurring monthly medical expenses (including but not limited to prescriptions, medications, physician bills, hospital bills, health insurance premiums, health insurance co-pays, and medical equipment and supplies). Adjusted monthly income is calculated by dividing the countable resources above $10,000 by 12 months then adding that amount to the countable income.

(ii.) Countable resources above $10,000 are used when calculating an individual's adjusted income. Countable resources include cash, savings, checking, certificates of deposit, money markets, stocks, bonds, trusts that an individual (or couple) owns and could easily convert to cash to be used for his or her support and maintenance, even if the conversion results in the resource having a discounted value. Details may be found in the Choices for Care Moderate Needs Program Manual.

(iii.) SSI Eligibility Rules:

If there is a question about whether or not resources or income are countable under this section, DAIL shall apply the SSI-related community Medicaid financial eligibility rules under HBEE.

(iv.) Post-eligibility rules related to transfer of assets and patient share shall not apply to individuals enrolled in the Moderate Needs Group.

7.102.6 Wait Lists

(a) Highest Needs Group: Enrollment in the Highest Needs Group shall not be subject to a wait list.

(b) High Needs Group:

(1) Enrollment in the High Needs Group shall be limited by the availability of funds as appropriated by the Vermont Legislature.

(2) If funds are unavailable, the names of eligible applicants shall be put on a waiting list. Applicants on a waiting list shall be admitted to the Choices for Care program as funds become available, according to procedures established by the DAIL and implemented by regional Choices for Care teams. The Choices for Care teams shall use professional judgment in managing the wait list and admitting applicants with the most pressing needs. The teams shall consider the following factors:

(i.) Unmet needs for ADL assistance,

(ii.) Unmet needs for IADL assistance,

(iii.) Behavioral symptoms,

(iv.) Cognitive functioning,

(v.) Formal support services,

(vi.) Informal supports,

(vii.) Date of application,

(viii.) Need for admission to or continued stay in a nursing facility,

(ix.) Other risk factors, including evidence of emergency need, and

(x.) Priority score.

(3) Individuals whose names are placed on a wait list shall be sent written notice that their name has been placed on the list, which shall include information about how the wait list operates.

(4) When an applicant's circumstances present a clear emergency, and DAIL staff is unavailable, the individual may be admitted to services without prior approval from the DAIL. Under these circumstances, DAIL staff shall complete a retrospective review to determine eligibility. Individuals who are determined not to be eligible may be responsible for the costs of services that have been received.

(5) All active program participants who meet the High Needs group clinical criteria at reassessment shall continue to be enrolled, provided that they continue to meet all other eligibility criteria

(6) Participants who are enrolled in the Highest Needs group and subsequently meet the High Needs group eligibility criteria shall be enrolled in the High Needs group and continue to be eligible to receive services.

(7) DAIL staff shall review the status of eligible applicants whose names have been on the waiting list for sixty (60) days to ensure that the applicant's needs have not changed.

(8) Any eligible applicant whose name has been on the waiting list for 60 days or more shall be given priority for enrollment over eligible applicants with similar needs whose names have been on the waiting list for a shorter amount of time.

(c) Moderate Needs Group:

(1) Enrollment in the Moderate Needs group shall be limited by the availability of funds as appropriated by the Vermont Legislature.

(2) If funds are unavailable at the local Moderate Needs provider of services, the names of any eligible applicants shall be put on a waiting list by the applicable Moderate Needs provider.

(3) Applicants on a waiting list shall be admitted to services using a priority system that utilizes the applicant's assessed risk factors as established by the DAIL in policy and procedures. Applicants who are categorically eligible for traditional Medicaid shall receive priority for purposes of enrollment.

7.102.7 Qualified Providers

(a) All Choices for Care providers must be pre-approved by the DAIL and shall abide by applicable laws, regulations, policies and procedures. The DAIL may terminate the provider status of an agency, organization, or individual that fails to do so. Choices for Care provider enrollment information may be found on the Adult Services Division website.

(b) All Choices for Care (CFC) provider agencies shall comply with all program standards, including the Universal Provider Standards, as well as program limitations as set forth in the program manual. This includes compliance with

federal Home and Community-Based Services (HCBS) regulations regarding person-centered planning, conflict of interest and setting requirements (42 CFR § 441 Subpart G).

(c) All CFC provider agencies must participate in quality management activities as defined by DAIL.

7.102.8 Authorization Requirements

(a) Eligibility Notification: All eligible applicants will receive a Notice of Decision from the Department of Vermont Health Access (DVHA) that communicates the financial, non-financial, and categorical eligibility for Medicaid and program eligibility for Choices for Care. Rules governing notices are fully set forth in Health Care Administrative Rule (HCAR) 8.100

(b) DAIL Service Authorization: All eligible participants (excluding nursing facility) will receive a notice from DAIL authorizing the amount of services and start dates. The DAIL notification will include:

(1) The basis for the decision;

(2) The legal authority for the decision;

(3) The right to request a variance;

(4) The right to appeal; and

(5) Information on how to file an appeal.

(c) Variances: The DAIL may grant variances to these regulations.

(1) Variances may be granted upon determination that the variance will otherwise meet the goals of the Choices for Care waiver and the variance is necessary to protect or maintain the health, safety or welfare of the individual.

(2) The need for a variance must be documented and the documentation presented at the time of the variance request.

(3) Applicants, participants, and providers may submit requests for a variance to DAIL at any time. Variance requests shall be submitted in writing, and shall include:

(A) A description of the individual's specific unmet need(s);

(B) An explanation of why the unmet need(s) cannot be met; and

(C) A description of the actual/immediate risk posed to the individual's health, safety or welfare.

(4) In making a decision regarding a variance request, DAIL may require further information and documentation to be submitted. DAIL also may require an in-home visit by DAIL staff. DAIL shall review a variance request and forward a decision to the individual, his or her authorized representative, if applicable, and to the provider(s). DAIL shall make a decision regarding a variance request within 30 days of receiving the request and shall send written notice of the decision, with appeal rights, within thirty (30) days.

(5) Retroactive Requests: Approved variances are effective no earlier than the date the request was received at DAIL. Retroactive requests will be considered only when a precipitating event necessitated an immediate increase of services exceeding the currently approved volume of services. The immediate increase must be necessary to prevent harm to the individual, a hospitalization or nursing facility admission. Retroactive requests must be submitted to DAIL in accordance with DAIL policy and procedure.

7.102.9 Terminations

(a) A participant may voluntarily withdraw from the Choices for Care program at any time for any reason.

(b) The State may terminate an individual's enrollment from the Choices for Care program for the following reasons:

(1) Clinical ineligibility;

(2) Medicaid financial, non-financial, and categorical ineligibility;

(3) Participant death;

(4) Stay out of state-exceeding 30 continuous days; or

(5) The participant not utilizing any of their Choices for Care services for more than 90 consecutive calendar days.

(c) In limited situations, a CFC provider may terminate or reduce, a service for one or more of the following reasons:

(1) Non-payment of patient share by the individual or authorized representative;

(2) The participant has requested that the service(s) be discontinued;

(3) The participant has moved out of the provider's designated service area;

(4) The participant chooses another provider;

(5) The participant, primary caregiver or other person in the home has exhibited behavior, including, but not limited to, physical abuse, sexual harassment, verbal threats or abuse or threatening behavior that poses a safety risk to agency staff; or

(6) The provider no longer provides the service(s) or discontinues operation.

Prior to termination of services, the provider must consult with DAIL program staff. Once a decision has been made to terminate services, the provider must notify the participant in writing according to section 7.102.11. Services may resume if the reason for termination of services has been remedied and the participant wishes to continue services.

7.102.10 Limitations

(a) Choices for Care shall not provide or pay for services to meet needs that can be adequately met by services available through other sources. This includes but is not limited to Medicare, Medicaid and private insurance coverage.

(b) Individuals whose only need for services is due to developmental disability or mental illness shall not be eligible for Choices for Care services.

7.102.11 Appeals, Grievances and Fair Hearings

(a) When decisions are made by the Medicaid program:

(1) The responsibilities of the Vermont Medicaid Program concerning the grievance and internal appeal system for Medicaid beneficiaries seeking coverage for Choices for Care services are set forth in the Health Care Administrative Rule (HCAR) 8.100. The rule also sets forth requirements for Notices of an Adverse Benefit Determination, continuing services pending appeal and potential beneficiary liability, and responsibilities regarding State fair hearings.

(2) For rules that govern Medicaid applicant and beneficiary appeals regarding financial, non-financial, categorical and clinical eligibility for Choices for Care, refer to Health Benefit Eligibility and Enrollment Rules (HBEE) Part 8 (State fair hearings/expedited eligibility appeals). HBEE Part 8 also sets forth the requirements for maintaining benefits/eligibility pending a State fair hearing. HBEE Part 7 (Section 68.00) contains the requirements for notices of an adverse action.

(b) When decisions are made by a provider to terminate or reduce services:

(1) Designated Home Health Agencies must follow the Vermont Designation rules with regards to notification, continuation of services and appeal rights.

(2) Enhanced Residential Care Home providers and Nursing Facilities must follow the applicable Vermont licensing regulations with regards to notification, continuation of services and appeal rights.

(3) All other providers must send a written notice to the individual containing the reasons for the action, the effective date of the action, the right to continuation of services, and appeal rights. Requirements for the timing and content of provider notices may be found in the Choices for Care program manuals.

7.102.12 Quality Assurance and Improvement

(a) The State shall maintain a quality management system that complies with Global Commitment federal Terms and Conditions and Comprehensive Quality Strategy.

(b) The quality management system shall include elements of discovery, remediation, and improvement.

(c) The quality management system shall align with federal requirements.

(d) The system shall include, but is not limited to, the following:

(1) Methods of ensuring the individual's health and welfare.

(2) An Ombudsman program that addresses the needs of participants in all settings.

(3) A process for receiving and responding to complaints.

(4) A process for receiving feedback from service participants and family members.

(5) A process for monitoring provider performance, including incident reports.

(6) A process for responding to suspicions of fraud.

(7) A process for ensuring that suspected abuse, neglect and exploitation is reported and addressed.

(e) Service providers shall comply with the requirements of the quality management system, including survey and certification procedures established by the State.

Internal Appeals, Grievances, Notices, and State Fair Hearings on Medicaid Services

8.100 Internal Appeals, Grievances, Notices, and State Fair Hearings on Medicaid Services (06/01/2018, GCR 17-090)

8.100.1 Introduction and Applicability

Rule 8.100 implements the responsibilities of the Medicaid Program pursuant to 42 CFR § 438, Subpart F, regarding a grievance and internal appeal system for Medicaid beneficiaries seeking Medicaid services. The rule also sets forth requirements for Notices of an Adverse Benefit Determination, continuing services pending appeal and potential beneficiary liability, and responsibilities regarding State fair hearings.[1]

The services listed below are not subject to the grievance rule at 8.100.8 and the internal appeal rule at 8.100.4. A Medicaid beneficiary may request a State fair hearing, pursuant to 8.100.5, regarding these services.

(a) Services funded with state-only dollars because federal participation is prohibited, and
(b) Services that are a coverage exception to Medicaid covered services.

For rules that govern Medicaid applicant and beneficiary appeals regarding financial, non-financial, and categorical eligibility for community Medicaid and Medicaid for long-term care services and supports and Medicaid premium determinations, refer to Health Benefit Eligibility and Enrollment Rules at Code of Vermont Rules 13-001-001 to 13-001-008.

8.100.2 Definitions

The following definitions shall apply for use in 8.100:

(a) **"AHS"** means the Agency of Human Services as the Medicaid Single State Agency.

(b) **"Authorized Representative"** means an individual, either appointed by a beneficiary or authorized under State or other applicable law, to act on behalf of the beneficiary in the internal appeal, grievance, or State fair hearing processes as permitted pursuant to 42 CFR § 435.923. Unless otherwise stated in law, the authorized representative has the same rights and responsibilities as the beneficiary in obtaining a benefit determination or in dealing with the internal appeal, grievance, and State fair hearing processes.

(c) **"Designated Agency/Specialized Service Agency"** means an agency designated or deemed by the Department of Mental Health or the Department of Disabilities, Aging, and Independent Living to provide and administer services, including service authorization decisions, for beneficiaries with mental health needs or developmental disabilities.

(d) **"Final Administrative Action"** means a final AHS order entered by the Human Services Board or, if the Secretary of AHS reverses the order of the Human Services Board pursuant to 3 VSA § 3091(h), then the Secretary's order.

(e) **"Grievance"** means an expression of dissatisfaction about any matter that is not an adverse benefit determination, including a beneficiary's right to dispute an extension of time proposed by the Medicaid Program and the denial of a request for an expedited appeal.

(f) **"Internal Appeal"** means an internal review by the Medicaid Program of an adverse benefit determination.

(g) **"Medicaid Program"** means (1) DVHA in its managed care function of administering services,

[1] The Human Services Board Fair Hearing Rules are at Code of Vermont Rules 13-020-002 (Part 1000).

including service authorization decisions, under the Global Commitment to Health Waiver ("the Waiver"), (2) a State department of AHS (i.e., Department for Children and Families; Department of Disabilities, Aging, and Independent Living; Department of Health; and Department of Mental Health) with which DVHA enters into an agreement delegating its managed care functions including providing and administering services such as service authorization decisions, under the Waiver, (3) a Designated Agency or a Specialized Service Agency to the extent that it carries out managed care functions under the Waiver, including providing and administering services such as service authorization decisions, based upon an agreement with a State department of AHS, and (4) any subcontractor performing service authorization decisions on behalf of a State department of AHS.

(h) **"Provider"** means a person, facility, institution, partnership, or corporation licensed, certified or authorized by law to provide services to a beneficiary.

(i) **"State Fair Hearing Request"** means a clear expression, either orally or in writing, by a beneficiary to have a decision by the Medicaid Program reviewed by the Human Services Board.

8.100.3 Notice Requirements

(a) General Requirements for Notices Sent by the Medicaid Program or AHS Pursuant to 8.100: The notice shall be compliant with 42 CFR § 438.10 including that the notice shall be:

(1) Written unless otherwise specified by this rule,
(2) In plain language,
(3) Accessible for persons with limited English proficiency.

(A) Persons with limited English proficiency shall be provided language services at no cost to the individual, including:

(i) Oral interpretation,
(ii) Written translations,
(iii) Taglines in non-English languages, including the availability of language services, and

(4) Accessible for persons with disabilities.

(A) Individuals with disabilities shall be provided with auxiliary aids and services at no cost to the individual, in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

(b) Notice of Adverse Benefit Determination: The Medicaid Program shall provide the beneficiary with timely and adequate written notice of an adverse benefit determination.

(1) Content of notice of adverse benefit determination: A notice of adverse benefit determination shall contain clear statements of the following:

(A) An explanation of the adverse benefit determination the Medicaid Program has taken or intends to take,
(B) The reason for the adverse benefit determination,
(C) The specific rule that supports the adverse benefit determination,
(D) The right to appeal, including how to request an internal appeal and the timeframe,
(E) An explanation of when there is a right to request a State fair hearing, including the exhaustion requirement and when exhaustion is deemed,
(F) The circumstances under which an appeal will be expedited and how to request it,
(G) The right to have services continue pending resolution of the appeal, including how to request

continuing services, the timeframe for requesting continuing services, and under what circumstances the beneficiary may be required to pay the costs of services that are provided pending resolution of the appeal,

(H) The methods for requesting an appeal and procedures for exercising other rights in 8.100.4, and

(I) The right of the beneficiary to be provided, upon request and free of charge, reasonable and timely access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination, including medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits.

(2) Timing of Notice of Adverse Benefit Determination, Including When Advance Notice is Required: The Medicaid Program shall mail the notice within the following timeframes:

(A) For a termination, suspension, or reduction of a previously authorized service, at least 11 days before the change will take effect.

(B) For denial of payment, at the time of any action affecting the claim.

(C) For standard service authorization decisions that deny or limit services, as expeditiously as the beneficiary's health requires but not more than 14 days following receipt of the request for service.

(D) For expedited service authorization decisions, as expeditiously as the beneficiary's health requires but not more than 72 hours after receipt of the request for service.

(E) For service authorization decisions not reached within the proper timeframes described in paragraphs (C) and (D) above, on the date that the timeframe expires.

(i) Service authorization decisions not reached within the proper timeframes constitute a denial and thus are an adverse benefit determination.

(F) If the Medicaid Program meets the criteria for extending the timeframe for standard and expedited service authorizations, it shall:

(i) Give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if s/he disagrees with the decision to extend the timeframe, and

(ii) Issue and carry out its decisions as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

(c) Notice of Resolution of Internal Appeal

(1) Content of notice of resolution of internal appeal

(A) The written notice shall include clear statements of the following:

(i) The decision, including the basis for the decision, in sufficient detail for the beneficiary to understand the decision,

(ii) A summary of the beneficiary's appeal,

(iii) A summary of the evidence or documentation used by the reviewer in making the decision, including clinical review criteria used to make a decision relating to medical care,

(iv) The date the decision was completed and the effective date of the decision,

(v) The telephone number of the Health Care Advocate at Vermont Legal Aid, Inc., and

(B) For appeals not resolved wholly in favor of the beneficiary:

(i) The right to request a State fair hearing, how to request a fair hearing, and the timeframe for doing so,
(ii) The circumstances in which a State fair hearing will be expedited and how to request it,
(iii) The right to have services continue pending resolution of the State fair hearing including how to request continuing services and the timeframe for doing so,
(iv) The timeframes, whether standard or expedited, in which AHS, which may include the Human Services Board, must take final administrative action, and
(v) That the beneficiary may, consistent with State policy, be held liable for the cost of continued services if the State fair hearing process results in a final administrative decision that upholds the Medicaid Program's adverse benefit determination.

(d) Notice of Resolution of Grievance: The Medicaid Program's written notice of resolution of a grievance shall contain clear statements of the following:

(1) The decision, including the basis or other rationale for the decision in sufficient detail for the beneficiary to understand the decision,
(2) A summary of the grievance,
(3) The telephone number of the Health Care Advocate at Vermont Legal Aid, Inc., and
(4) If the decision is adverse to the beneficiary, the notice must inform the beneficiary of his/ her right to initiate a grievance review pursuant to 8.100.8(j) and explain how to do so.

8.100.4 Internal Appeals

(a) Internal Appeal System: The Medicaid Program shall maintain an internal appeal system, including an expedited appeal process, for a beneficiary to appeal an adverse benefit determination. The system shall not have more than one level of internal appeal.

(b) Right to Internal Appeal; Exception for Change in Law

(1) A beneficiary may file an internal appeal of an adverse benefit determination with the Medicaid Program.

(2) There is no right to an internal appeal when the sole issue is a federal or state law requiring an automatic change adversely affecting some or all beneficiaries.

(c) Provider Decisions: Network provider decisions that do not require a service authorization are not adverse benefit determinations of the Medicaid Program and are not subject to the internal appeal process.

(d) Exhaustion Requirement; Deemed Exhaustion; Request for Review Made to Human Services Board Prior to Exhaustion

(1) Exhaustion Requirement: A beneficiary may only request a State fair hearing after receiving notice of resolution of an internal appeal under 8.100.3(c) that the Medicaid Program upheld an adverse benefit determination, except that the beneficiary shall be deemed to have exhausted the internal appeal process pursuant to paragraph (d)(2) below.

(2) Deemed exhaustion: If the Medicaid Program fails to comply with the requirements regarding notice content and timing at 8.100.3(c) and 8.100.4(n), (o) and (p), exhaustion of the internal appeal process shall be deemed and a beneficiary may immediately request a State fair hearing.

(3) Request for Review Made to Human Services Board Prior to Exhaustion: If a beneficiary wrongly files a request for review with the Human Services Board prior to exhausting the internal appeal process, where exhaustion is required, AHS and the Medicaid Program shall provide the beneficiary with appropriate assistance with filing an internal appeal with the Medicaid Program.

(e) Filing of Internal Appeal, Including Time for Appealing

(1) Who May File Internal Appeal: A beneficiary or, as state law permits and with the written consent of the beneficiary, a provider or authorized representative (if not already specified in authorized representative's scope of authority), may initiate an internal appeal.

(A) When "beneficiary" is used in 8.100.4, it includes providers and authorized representatives except that providers may not request that services be continued pending appeal.

(2) How to Appeal: An internal appeal may be filed orally or in writing.

(A) An oral inquiry seeking to appeal an adverse benefit determination shall be treated as an appeal for purposes of establishing the filing date for the appeal.

(B) A beneficiary must follow an oral appeal with a written appeal except when the beneficiary requests expedited resolution of the appeal. The Medicaid Program shall have discretion to find that a beneficiary has good cause for not following an oral appeal with a written appeal.

(3) Time for Filing Appeal: A beneficiary must file an appeal with the Medicaid Program within 60 days of the date the Medicaid Program mailed the notice of adverse benefit determination. The date of the appeal, if mailed, and the date the Medicaid Program mailed the notice of adverse benefit determination, is the postmark date. For adverse benefit determination notices that are mailed by the Medicaid Program, the postmark date is one business day after the date of the notice.

(f) No Punitive Action Against Providers: The Medicaid Program shall ensure that no punitive action is taken against a provider who requests or supports a beneficiary's internal appeal.

(g) Assistance with Appeal and Requesting a State Fair Hearing:

(1) The Medicaid Program shall:

(A) Give beneficiaries any reasonable assistance in initiating and participating in the internal appeal and the State fair hearing processes including by helping the beneficiary to submit his/her request. Help shall include completing forms and taking other necessary steps,

(i) Assistance includes auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(B) Provide appropriate assistance in filing a request for a State fair hearing to any beneficiary who wrongly filed a request for review with the Human Services Board prior to exhaustion of the internal appeal, if the beneficiary wishes to pursue a State fair hearing, and

(C) Respond to any clear indication (oral or written) that a beneficiary wishes to present his/her case to a reviewing authority by helping the beneficiary to submit a request for an internal appeal (or a State fair hearing, where appropriate).

(2) Request for Review by Human Services Board Prior to Exhaustion: See 8.100.4(d)(3)

(h) Written Acknowledgement of Appeal: The Medicaid Program shall mail acknowledgement of the appeal to the beneficiary within five days of its receipt of the appeal.

(i) Withdrawal of Appeal: Appeals may be withdrawn orally or in writing at any time.

(1) If an internal appeal is withdrawn orally, the Medicaid Program shall acknowledge the withdrawal in writing within five days.

(j) Parties to the Appeal: The parties to an internal appeal are the beneficiary or his/her authorized representative, or the legal representative of a deceased beneficiary's estate.

(k) Information to Resolve Appeal: The Medicaid Program shall act promptly and in good faith to obtain any necessary information to resolve the appeal. For purposes of this paragraph, "necessary information" may include the results of any face-to-face clinical evaluation or second opinion that may be required.

(l) Appeals Reviewer: Individuals who make a decision on an internal appeal:

(1) Shall not have been involved in any previous level of review or decision making, nor be a subordinate of any such individual,
(2) Shall have appropriate clinical expertise in treating the beneficiary's condition or disease when deciding an appeal of a denial based on medical necessity, and
(3) Shall consider all comments, documents, records, and other information submitted by the beneficiary or his/her representative or provider without regard to whether such information was submitted or considered in the initial adverse benefit determination.

(m) Internal Appeal Process

(1) Participation in Appeal Meeting: The beneficiary, his/her authorized representative, or his/her provider, if requested by the beneficiary, has the right to participate in person, by phone, or in writing in the meeting in which the Medicaid Program is considering the issue that is the subject of the appeal. Participation includes the right to present evidence and testimony and make factual and legal arguments.

(A) The Medicaid Program shall inform the beneficiary of the time available for participation in the internal appeal sufficiently in advance of the resolution timeframe for the appeal including, if an appeal meeting will be held, sufficiently in advance of the meeting.

(2) Submission of Information: The beneficiary, the authorized representative, or the provider may submit additional relevant information that supplements or clarifies information that was previously submitted.

(3) Right to Examine and Get Copies of Record: Prior to the appeal meeting, the Medicaid Program shall timely provide the beneficiary, his/her authorized representative, or his/her provider with an opportunity to examine, and, if requested, get copies of all the information in its possession or control relevant to the appeal process and the subject of the appeal. The Medicaid Program shall not charge the beneficiary for copies of any records or other documents necessary to resolve the appeal. These records shall include:

(A) The beneficiary's case record, including medical records, other records and documents, and any new or additional evidence considered, relied on, or generated by the Medicaid Program, or at its direction, that is related to the appeal, and

(B) Other information relevant to the beneficiary's adverse benefit determination, including relevant policies or procedures which shall include medical necessity criteria and any processes, strategies, or evidentiary standards used in setting service limits.

(4) Scheduling the Appeal Meeting: The Medicaid Program shall timely notify the beneficiary when the appeal meeting is scheduled. If necessary, the appeal meeting will be rescheduled to accommodate individuals wishing to participate.

(A) If an appeal meeting cannot be scheduled within the timeframe for resolving the appeal, including if the timeframe is extended pursuant to paragraph (o) below, the Medicaid Program shall make a decision that resolves the appeal without a meeting with the beneficiary, his/her authorized representative, or provider. The beneficiary, his/her authorized representative, or provider shall have an opportunity to submit evidence and argument by other means to the appeals reviewer for consideration in making a decision.

(n) Standard Time for Resolution of Internal Appeal

(1) The Medicaid Program shall decide an internal appeal and provide written notice as expeditiously as the beneficiary's health condition requires, but not longer than 30 days after it receives the appeal.

(o) Extension of Time to Resolve Internal Appeal

(1) The Medicaid Program may extend the time for resolving an internal appeal by up to 14 days under the following circumstances:

(A) By request of the beneficiary, or
(B) If the Medicaid Program shows that there is need for additional information and how the delay is in the best interest of the beneficiary.

(2) If the extension is not at the request of the beneficiary, pursuant to paragraph (1)(A) above, the Medicaid Program shall:

(A) Make a reasonable effort to give the beneficiary prompt oral notice of the delay,
(B) Give the beneficiary written notice, within two days of a decision based on paragraph (1)(B) above, of the reason for its decision to extend the time and an explanation of the right to file a grievance if the beneficiary disagrees with the decision, and
(C) Resolve the appeal as expeditiously as the beneficiary's health requires and no later than the date the extension expires.

(3) Maximum Time for Resolution of Appeals

(A) The maximum time, including any extensions, is:

(i) 44 days for standard resolution of an appeal (30 days plus 14 days), or
(ii) 17 days for expedited resolution of an appeal (72 hours plus 14 days).

(p) Expedited Resolution of Internal Appeal

(1) The Medicaid Program shall have an expedited process for resolving internal appeals when:

(A) It determines that the standard for expedited resolution is met, when the request is from the beneficiary, or
(B) The provider indicates that the standard for expedited resolution is met, when a provider makes a

request on a beneficiary's behalf or supports a beneficiary's request.

(2) Standard for Expedited Resolution: The standard for expedited resolution of an internal appeal is that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

(3) Denial of Request for Expedited Resolution of Appeal, Including Timeframe

(A) If the Medicaid Program determines that the standard for an expedited appeal is not met, the Medicaid Program shall:

(i) Resolve the appeal in accordance with the standard timeframe,
(ii) Make reasonable efforts to give the beneficiary prompt oral notice of the denial, and
(iii) Send written notice of the reason for the denial to the beneficiary within two days of the oral notice. The notice shall explain that the request does not meet the criteria for expedited resolution, that the appeal will be processed within the standard 30-day timeframe, and give notice of the right to file a grievance of the denial of the request for expedited resolution.

(4) Approval of Request for Expedited Resolution of Appeal, Including Timeframe

(A) If the Medicaid Program determines that the expedited appeal request meets the standard for expedited resolution, the Medicaid Program shall resolve the appeal and notify the beneficiary of the decision within 72 hours of its receipt of the expedited appeal. The Medicaid Program shall make reasonable efforts to give the beneficiary prompt oral notice of the denial which shall be followed by written notice.

(5) Right to Expedited State Fair Hearing: A beneficiary may request an expedited State fair hearing pursuant to 8.100.5(k) when the Medicaid Program approved the request for expedited resolution of an internal appeal:

(A) But the decision is wholly or partially adverse to the beneficiary, or
(B) The expedited internal appeal is not timely resolved by the Medicaid Program.

(q) Notice of Resolution of Internal Appeal: See 8.100.3(c).

8.100.5 State Fair Hearings

(a) State Fair Hearing System: AHS shall maintain a fair hearing system, including an expedited fair hearing process, that meets the requirements of the United States Constitution, the Vermont Constitution, 42 CFR § 431, Subpart E, the due process standards set forth in Goldberg v. Kelly, 397 U.S. 254 (1970), the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, and Section 1557 of the Affordable Care Act, and implementing regulations.

(b) State Fair Hearing Entity: The Human Services Board is an independent part of AHS that is designated by state law to conduct State fair hearings when the final resolution of an internal appeal is adverse to the beneficiary.[2]

(c) Other Applicable Rules: Fair hearings shall be conducted in accordance with rules promulgated by the Human Services Board pursuant to 3 VSA § 3091(b).[3]

(d) Notification of State Fair Hearing Rights

[2] 3 VSA § 3090(b), 3091(a)
[3] Human Services Board Fair Hearing Rules, Code of Vermont Rules 13-020-002 (Part 1000)

(1) AHS shall issue and publicize its hearing procedures.

(2) AHS shall, at the times specified at paragraph (d)(3) below, inform every applicant or beneficiary in writing of the following:

(A) The right to a State fair hearing and right to request an expedited State fair hearing;
(B) The methods for requesting a State fair hearing,
(C) That the beneficiary can represent him or herself or use counsel, a relative, a friend, or other spokesperson, and
(D) The timeframes in which AHS must take final administrative action on a State fair hearing request.

(3) AHS shall provide the information at paragraph (d)(2) above:

(A) At the time an individual applies for Medicaid, and
(B) When a beneficiary requests a State fair hearing.

(e) Right to a State Fair Hearing; Exhaustion Requirement: Except for a beneficiary who seeks review of a service not subject to the internal appeal process pursuant to 8.100.1, a beneficiary shall have a right to request a State fair hearing only after exhausting the internal appeal process or if s/he is deemed to have exhausted the process pursuant to 8.100.4(d).

(f) When a Hearing is Required; Exception: AHS shall grant an opportunity for a hearing to any beneficiary who is dissatisfied with the final resolution of the internal appeal. There is no right to a hearing if the sole issue is a state or federal law requiring an automatic change adversely affecting some or all beneficiaries. A beneficiary retains the right to a State fair hearing in an appeal of the application of the law to the facts of an individual's case.

(g) Filing of State Fair Hearing Requests, Including Ongoing Continuing Services, and Timeframe

(1) Who May Request a State Fair Hearing: A beneficiary may request a State fair hearing, and a provider or an authorized representative may request a State fair hearing on behalf of the beneficiary, as consistent with state law and with the written consent of the beneficiary.

(2) How to Request a State Fair Hearing and ongoing continuing services:

(A) A beneficiary may request a State fair hearing and ongoing continuing services orally or in writing:

(i) By telephone,
(ii) Via mail,
(iii) In person,
(iv) Via the internet, and
(v) Through other commonly available electronic means.

(B) Time for Requesting a State Fair Hearing and ongoing continuing services: A beneficiary must request a State fair hearing within 120 days of the date the Medicaid Program mailed the notice of resolution of the internal appeal, or, when regarding services not subject to the internal appeal process pursuant to 8.100.1, within 120 days from the date the Medicaid Program mailed the notice of decision. A beneficiary who is receiving continuing services must request a State fair hearing and the continuation of services pending the outcome of the State fair hearing within 11 days after the Medicaid Program mails the notice of resolution of the internal appeal. The date of mailing by the Medicaid

Program is the postmark date. The postmark date is one business day after the date of the notice.

(h) AHS Responsibilities Related to State Fair Hearing Requests: AHS shall:

(1) Assure that the methods for requesting a State fair hearing include an opportunity for the beneficiary to request an expedited State fair hearing,
(2) Assist the beneficiary in submitting a State fair hearing request, and
(3) Not limit or interfere with a beneficiary's freedom to request a State fair hearing.

(i) Parties to the State Fair Hearing: The parties to the State fair hearing are the Medicaid Program and the beneficiary or his/her authorized representative or the legal representative of a deceased beneficiary's estate.

(j) Standard Timeframe for Final Administrative Action[4]; Extension of Time

(1) AHS, which may include the Human Services Board, shall take final administrative action within 90 days from the date the beneficiary filed an internal appeal with the Medicaid Program, not including the number of days the beneficiary took to subsequently file for a State fair hearing. For services not subject to the internal appeal process pursuant to 8.100.1, AHS shall take final administrative action within 90 days from the date the beneficiary requests a State fair hearing.

(2) Extension of Time: AHS, which may include the Human Services Board, shall take final administrative action within the timeframes in paragraph (j)(1) above except in unusual circumstances. If there are unusual circumstances, AHS shall document the reason for the delay in the beneficiary's record. Unusual circumstances occur when:

(A) AHS cannot reach a decision because the beneficiary requests a delay or fails to take an action that is required for resolution of the State fair hearing request, or
(B) There is administrative or other emergency that is beyond the control of AHS.

(k) Expedited Resolution of State Fair Hearing, Including Timeframe

(1) Standard for Expedited Resolution: AHS shall maintain an expedited State fair hearing process for a beneficiary to request expedited resolution of a State fair hearing when the Medicaid Program has determined that the time for standard resolution may jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

(A) Right to Expedited State Fair Hearing: A beneficiary may request expedited resolution of a State fair hearing when the Medicaid Program has determined that the standard for such resolution, described at paragraph (k)(1) above has been met, and, for services that are subject to the internal appeal process:

(i) The Medicaid Program did not adhere to the time limit for resolution for an expedited internal appeal, or
(ii) The Medicaid Program timely resolved the expedited internal appeal but the notice of resolution was wholly or partially adverse to the beneficiary.

(2) Time for Expedited Resolution: AHS, which may include the Human Services Board, shall take final administrative action as expeditiously as the beneficiary's health requires but not later than three working days after AHS receives, from the Medicaid Program, the case record and information for an appeal that the Medicaid Program indicates met the standard for expedited appeal.

[4] The State fair hearing process is subject to 3 VSA § 3091(h).

(3) Extension of Time for Resolution: AHS, which may include the Human Services Board, must take final administrative action within the timeframe in paragraph (k)(2) above except in unusual circumstances. Unusual circumstances are defined at paragraph (j)(2) above. If there are unusual circumstances, AHS may extend the time for resolution consistent with paragraph (j)(2) above. AHS shall document the reason for the delay in the beneficiary's record.

(l) Request for Review Made To Human Services Board Prior to Exhaustion: See 8.100.4(d)(3)

8.100.6 Continuation of Services While Internal Appeal or State Fair Hearing is Pending; Beneficiary Liability for Services

(a) Request for Continuing Services: The Medicaid Program shall continue the beneficiary's services if the following circumstances are met:

(1) The beneficiary appeals in a timely manner,
(2) The beneficiary timely files for continuing services which means within 11 days of the Medicaid Program sending the notice of adverse benefit determination, or before the effective date of the proposed adverse benefit determination, whichever is later,
(3) The appeal involves the termination, suspension, or reduction of a previously authorized service,
(4) The services were ordered by an authorized provider, and
(5) The period covered by the original authorization has not expired.

(b) Duration of Continuing Services: At the beneficiary's request, the Medicaid Program shall continue or reinstate services while the internal appeal and State fair hearing is pending, until one of the following occurs:

(1) The beneficiary withdraws the internal appeal or request for a State fair hearing,
(2) The beneficiary fails to request a State fair hearing and continuation of benefits within 11 days of the date the Medicaid Program mails the notice of resolution of the internal appeal.
(3) There is a final administrative decision on the State fair hearing request that is adverse to the beneficiary.

(c) Exception: Continuation of services without change does not apply when the appeal is based solely on a federal or state law requiring an automatic change adversely affecting some or all beneficiaries, or when the decision does not require the minimum advance notice pursuant to 42 CFR § 431.213.

(d) Beneficiary Liability for Services Furnished While Internal Appeal or State Fair Hearing is Pending:

(1) The Medicaid Program may recover from the beneficiary the cost of services furnished to the beneficiary while the internal appeal and State fair hearing were pending if the following criteria is met:

(A) The services were furnished solely because of the beneficiary's request for continued services,
(B) The beneficiary withdraws the appeal before the internal appeal decision or State fair hearing decision is made, or following the final resolution of an internal appeal or a State fair hearing upholding the Medicaid Program's adverse benefit determination, and
(C) Recovery from the beneficiary is consistent with AHS policy on recovery and the Medicaid Program determines that the beneficiary should be liable for the service costs.

(2) If an internal appeal or a State fair hearing relates to a concurrent review determination for emergency services or urgent care, the service shall be continued without liability to the beneficiary until the Medicaid Program has notified the beneficiary of its final resolution, consistent with State fair hearing rules.

8.100.7 Providing or Paying for Services Following Resolution of an Internal Appeal or a State Fair Hearing

(a) Services Not Furnished While Appeal Pending: If the Medicaid Program or AHS, including the Human Services Board, reverses a decision to deny, limit, or delay services that were not furnished while the internal appeal or State fair hearing was pending, or if AHS decides in the beneficiary's favor before the hearing, the Medicaid Program shall authorize or provide the disputed services as expeditiously as the beneficiary's health condition requires but no later than 72 hours from the date the Medicaid Program receives notice reversing the determination.

(b) Services Furnished While Appeal Pending: If the Medicaid Program or AHS, including the Human Services Board, reverses a decision to deny, limit, or delay services that were furnished while the appeal was pending, the Medicaid Program shall pay for those services in accordance with State policy.

8.100.8 Beneficiary Grievances

(a) Grievance System and the Right to Grieve: The Medicaid Program shall have a grievance system that allows beneficiaries to grieve a matter that is not an adverse benefit determination including denial of a request for an expedited appeal, an extension of time by the Medicaid Program for deciding a service authorization or resolving an internal appeal, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the failure to respect a beneficiary's rights.

(b) Filing a Grievance

(1) Who May Grieve: A beneficiary, authorized representative, or provider may file a grievance with the Medicaid Program consistent with the requirements at 8.100.4(e)(1).

(2) How to Grieve: A beneficiary may file a grievance orally or in writing.

(3) Timeline for Filing Grievance: A beneficiary may file a grievance at any time.

(c) Assistance: The Medicaid Program shall give beneficiaries assistance in the grievance process consistent with the requirements of 8.100.4(g).

(d) Written Acknowledgement: The Medicaid Program shall mail the beneficiary acknowledgement of the grievance within five days of receipt of the grievance.

(e) Withdrawal of Grievances: Grievances may be withdrawn orally or in writing at any time. The Medicaid Program shall acknowledge a beneficiary's oral withdrawal in writing within five days.

(f) No Punitive Action Against Providers: The Medicaid Program shall ensure that no punitive action is taken against a provider who files a grievance or supports a beneficiary's grievance.

(g) Grievance Process

(1) Grievance Reviewer:

(A) Individuals who are making the decision on a grievance shall not have been involved in any previous level of review or decision making, nor be a subordinate of such individual.

(B) A grievance shall be decided by an individual who possesses the requisite clinical expertise in treating the beneficiary's condition when deciding:

(i) A grievance regarding the denial of a request for expedited resolution of an appeal, or
(ii) A grievance that involves clinical issues.

(2) Information to Resolve Grievance: The Medicaid Program shall act promptly and in good faith to obtain any necessary information to resolve the grievance. "Necessary information" may include information described at 8.100.4(k).

(3) Opportunity to See Records: The Medicaid Program shall provide the beneficiary, free of charge, with all the information in its possession or control relevant to the grievance process and the subject of the grievance, including:

(A) The beneficiary's case record, including medical records and other records and documents related to the grievance, and
(B) Other information relevant to the beneficiary's grievance including relevant policies and procedures.

(h) Time for Resolving; Grievance Not Timely Resolved; Extension of Timeframe

(1) Time for Resolving: The Medicaid Program shall decide the grievance and provide notice of the decision as expeditiously as the beneficiary's health condition requires but not more than 90 days from its receipt of the grievance.

(2) Grievance Not Timely Resolved: If the Medicaid Program does not act upon the grievance within the time for resolution, the beneficiary may request an internal appeal pursuant to the definition of adverse benefit determination at 1.101.

(3) Extension of timeframe: The Medicaid Program may extend the timeframe for deciding a grievance consistent with the requirements of 8.100.4(o).

(i) Requirements of Notice of Resolution: See 8.100.3(d).

(j) Grievance Review Process

(1) Filing a Grievance Review: If a grievance is decided in a manner adverse to the beneficiary, the beneficiary may request a review by the Medicaid Program within 11 days after the Medicaid Program mails the notice of resolution of the grievance. The mailing date of the notice is the postmark date. The postmark date is one business day after the date of the notice.

(2) Written Acknowledgement: The Medicaid Program shall acknowledge a grievance review request within five days of receipt.

(3) Grievance Reviewer: The grievance review shall be conducted by an individual who was not involved in deciding the grievance under review and is not a subordinate of such individual.

(4) Disposition

(A) The grievance review shall assess the merits of the grievance issue, the process employed in reviewing the issue, and the information considered in making a final determination. The primary purpose of the review shall be to ensure that the grievance process has functioned in an impartial manner and that the response was consistent with the issues and/or facts presented.

(B) The beneficiary shall be notified in writing of the findings of the grievance review within 90 days.

9.103 Supervised Billing (2/22/18, GCR 17-073)

9.103.1 Definitions

For the purposes of this rule, the term:

(a) **"Qualified Licensed Provider"** means a provider who is licensed and enrolled in Vermont Medicaid and acting within his or her scope of practice.

(b) **"Qualified Non-Licensed Provider**" means a provider that is actively working towards licensure as specified by his or her profession.

(c) **"Supervised Billing"** means that a qualified licensed provider can bill for covered clinical services within his or her scope of practice provided by a qualified non-licensed provider when the qualified non-licensed provider is under direct supervision of the qualified licensed provider.

9.103.2 Qualified providers

(a) A qualified licensed provider for purposes of this rule is:

(1) A physician or a licensed osteopathic physician certified in psychiatry by the American Board of Medical Specialties; or
(2) A psychiatric nurse practitioner; or
(3) A psychologist; or
(4) A marriage and family therapist; or
(5) A clinical mental health counselor; or
(6) A clinical social worker; or
(7) A Board Certified Applied Behavior Analyst; or
(8) An alcohol and drug counselor.

(b) A qualified non-licensed provider for purposes of this rule is:

(1) A doctoral degree or master's degree level mental health practitioner, including clinical social workers, clinical mental health counselors, and marriage and family therapists, actively fulfilling post-degree supervised practice hours as outlined by the Office of Professional Regulation in the Office of the Secretary of State; or
(2) A psychiatric nurse practitioner actively fulfilling supervised practice hours as outlined by the Office of Professional Regulation in the Office of the Secretary of State; or
(3) A psychologist actively fulfilling supervised practice hours as outlined by the Office of Professional Regulation in the Office of the Secretary after receiving a doctoral or master's degree in psychology; or
(4) A master's degree level Applied Behavior Analyst actively fulfilling post-degree supervised practice hours as outlined by the Office of Professional Regulation in the Office of the Secretary of State; or
(5) An addiction counselor who is:

(A) A master-level addiction counselor actively fulfilling the required number of hours of supervised work experience providing alcohol/drug counseling services, commensurate with their degree as outlined by the Office of Professional Regulation in the Office of the Secretary of State; or

(B) In possession of (or will possess within 180 days of hire or up to the date of the second exam offered following hire) a Vermont Addiction Apprentice Professional certificate (AAP) and providing services within the restrictions required by the Office of Professional Regulation in the Office of the Secretary of State; or
(C) In possession of an Alcohol and Drug Counselor (ADC) certification and providing services within the restrictions required by the Vermont Office of Professional Regulation.

9.103.3 Conditions for Supervised Billing

For a qualified licensed provider to bill for clinical services provided by a qualified non-licensed provider as supervised billing, the following conditions must be met:

(a) The qualified licensed provider shall:

(1) Adhere to the supervision requirements specified by his or her scope of practice, including regular, face-to-face ongoing supervision to the qualified non-licensed provider; and
(2) Be available immediately in person or by phone within 15 minutes themselves or ensure that another qualified licensed provider operating within their scope of practice is available immediately in person or by phone within 15 minutes; and
(3) Sustain an active part in the ongoing care of the patient, including sign off on the treatment plan; and
(4) If the qualified non-licensed provider determines neuropsychological testing may be needed, perform a face-to-face assessment with the patient to determine if it is medically necessary and which tests should be ordered and administered.

(b) The qualified non-licensed provider shall be actively working towards professional licensure or possess an AAP certification (or will possess within 180 days of hire or up to the date of the second exam offered following hire) or ADC; and

(1) For mental health practitioners, Applied Behavior Analysts, and addiction counselors, be listed on the roster that is maintained by the Office of Professional Regulation in the Office of the Secretary of State for his or her profession; or
(2) For Psychiatric Nurse Practitioners, be a registered nurse with a collaborative provider agreement as required by the Office of Professional Regulation in the Office of the Secretary of State.

(c) Non-licensed providers described in subsection (b) above who have been on the roster that is maintained by the Office of Professional Regulation in the Office of the Secretary of State for more than five years after January 1, 2016 will no longer be eligible under Medicaid to provide clinical services.

9.103.4 Non-Reimbursable Services

(a) Services rendered by any provider who is eligible to be enrolled as a Vermont Medicaid provider but has not applied to be a Vermont Medicaid provider.
(b) Services performed by a non-licensed provider who cannot practice independently and is not actively working toward licensure.

Pharmaceutical Manufacturer Fee

10.100 Pharmaceutical Manufacturer Fee (5/26/17, GCR 16-120)

(a) Pursuant to 33 V.S.A. § 2004, a fee shall be collected from each pharmaceutical manufacturer or labeler of prescription drugs that are paid for by the Department of Vermont Health Access for individuals participating in Medicaid, Dr. Dynasaur or VPharm. The fee shall be 1.5 percent of the previous calendar year's prescription drug spending by the Department of Vermont Health Access and shall be assessed based on manufacturer labeler codes.

(b) The Department of Vermont Health Access shall annually provide the manufacturer or labeler with an invoice reflecting the fee described in subsection (a) above. This amount will be based on paid claims data under the State's programs. The manufacturer or labeler shall remit the invoiced amount according to instructions provided by the Department of Vermont Health Access.

(c) In the event the manufacturer or labeler believes an error in billing has occurred, the manufacturer or labeler shall notify the Department of Vermont Health Access in writing within 30 days of receipt of the bill. This notification shall be accompanied by written materials setting forth the basis for the requested review.

(d) The Department of Vermont Health Access shall maintain on its website a list of the manufacturers or labelers who have failed to provide timely payment. Timely payment means payment received by the Department of Vermont Health Access within 30 days or less of the date that the written invoice was provided to the manufacturer or labeler, or upon resolution of the review process described in subsection (c) above. This list will be updated at least annually.