VHCA

Vermont Health Care Association

Representing Quality Health Care Homes

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Comments on Governor's Proposed FY2025 Budget

In support of increased Enhanced Residential Care rates, schedule of regular ACCS/ERC updates, and an updated rate stabilization plan for Skilled Nursing Facilities.

Assisted Living Residences (ALR) and Residential Care Homes (RCH):

Medicaid payments of concern to ALR/RCH providers in the FY2025 Budget:

- Assistive Community Care Services (ACCS) - Basic bundle of services.
- Enhanced Residential Care (ERC) - Three tiers of enhanced services, depending on resident needs.

VHCA testified on the details of these rates in 2023 when HHS reviewed the DVHA report: "**Specific Home- and Community-Based Service Provider Rate Study**"

Report found shortfalls between cost of services and reimbursement that would require significant increases to close:

- ACCS Rates: 79%
- ERC Tier 1: 13%
- ERC Tier 2: 37%
- ERC Tier 3: 60%

Access to ALR / RCH for residents using Medicaid payments has declined since 2020, especially for ERC level services. These data go through summer, 2023. Red text marks 2023 changes.

Provider type	# of facilities	# of ACCS providers	# of ERC providers
Residential Care	92	75	49
Assisted Living	18	13	11

Opened Since 2020:

Residential Care

County	Facility	Beds	ACCS/ERC
Caledonia	Parkway House	5	ACCS
Chittenden	Atwood House	3	
Orange	Valley View at Cottage Street	11	ACCS
Rutland	Burke Family Women's Home	5	ACCS

Assisted Living:

Chittenden	Maple Ridge Lodge	81	
Washington	Chestnut Place	54	ACCS

Closures Since 2020:

County	Facility	Beds	ACCS/ERC
Addison	Ringer's CCH	9	ACCS & ERC
Addison	Vergennes Residential Care	18	ACCS & ERC
Bennington	Watson House	16	ACCS & ERC
Bennington	Manes House	11	ACCS & ERC
Chittenden	Gazebo Senior Living (converted to Independent Living)		ACCS & ERC
Chittenden	South Harbor Senior Living	70	ACCS
Franklin	Holiday House	42	ACCS & ERC
Lamoille	Forest Hill RCH	21	ACCS & ERC
Orange	Windover House	15	ACCS & ERC
Orange	Valley View Home for Retired	7	ACCS & ERC
Orleans	Newport	8	ACCS
Rutland	Loretto Home	57	ACCS & ERC
Rutland	Misty Heather Morn	16	ACCS & ERC
Rutland	Gables – converted all to Independent Living		
Rutland	7 Royce St	4	ACCS
Washington	Fortier's CCH	10	ACCS
Windham	Holton Home	35	ACCS & ERC

Assisted Living Residences (ALR) and Residential Care Homes (RCH):

FY2024 Budget included key investment to align ACCS reimbursement with costs:

- 80% Rate Increase
- Moves from $47.25/day to $84.66 / day

Adding in regular inflationary updates / rate reviews would avoid falling so far behind in the future.

FY2024 Budget increased ERC rates by 4%. We are asking that FY2025 continue the progress from FY2024 by fully reimbursing for ERC services.

Bringing Medicaid reimbursement equal to costs is especially important as the state updates ALR/RCH licensing regulations. Our ERC providers cannot upgrade their operations and staffing to meet new licensing expectations if they are still under-paid for *current* services.

VHCA Request for ACCS / ERC in FY2025 Budget:

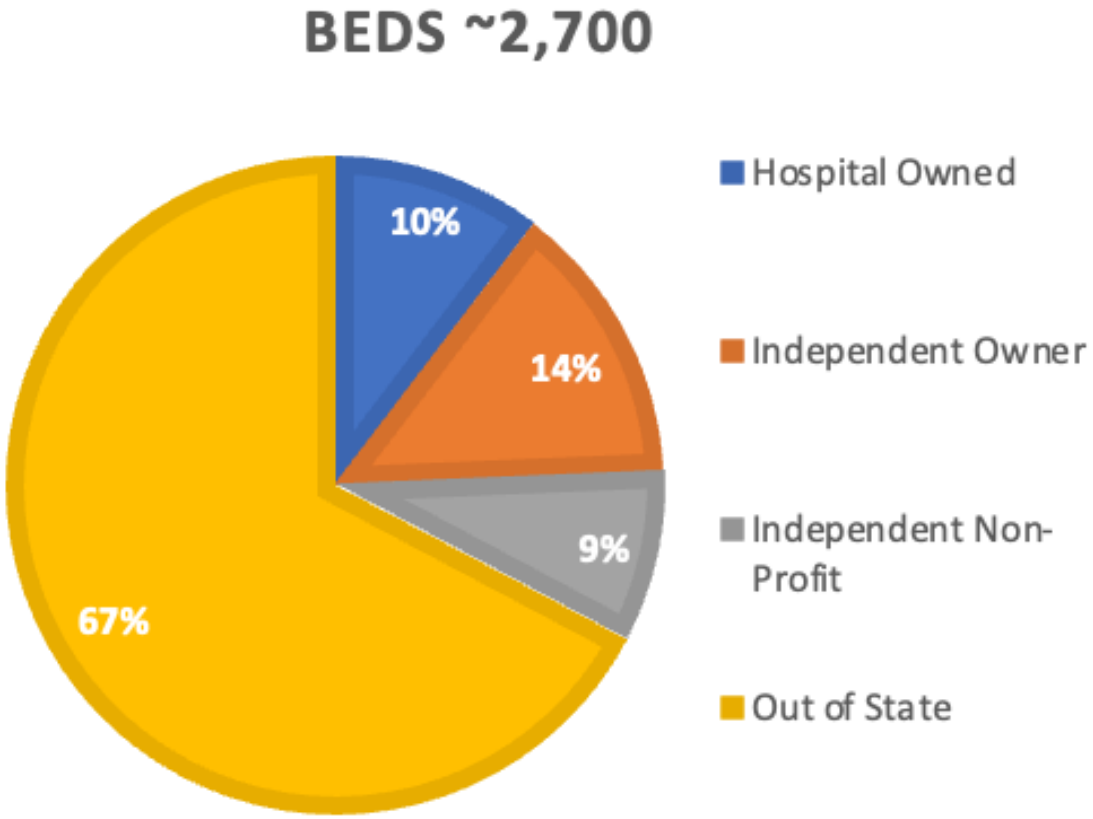
- Fully implement ERC Tier 1-3 increases recommended in 2023 DVHA study – Approximately $7.9 million (gross)

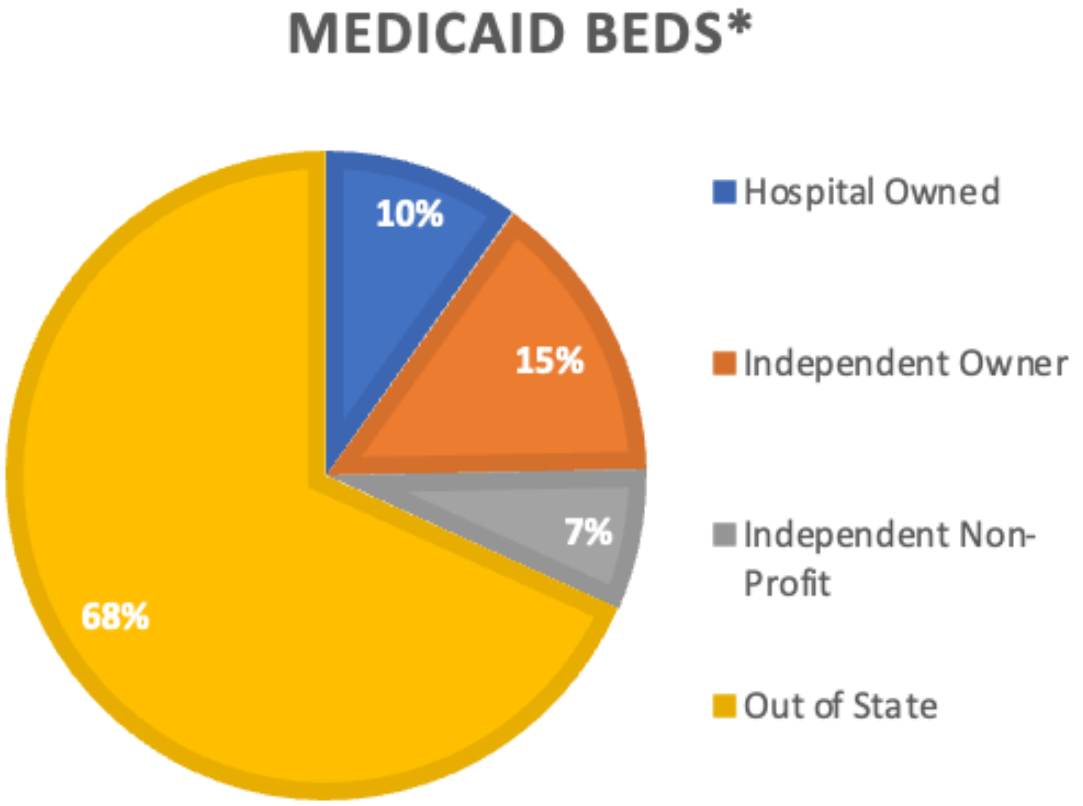
- Institute regular schedule of rate updates to avoid having to close large shortfalls in the future.

VHCA is also a part of the Long-Term Care Crisis Coalition. We support the LTCCC's overall request for full funding of the 2023 rate study across provider types.

Skilled Nursing Facilities (SNFs):

For purposes of FY2025 Budget Discussion we are looking at SNFs paid through regular LTC Medicaid – excluding private-pay / continuous care facilities and the Vermont Veterans Home. All providers accepting LTC Medicaid have more than 50% of current population covered through that payment structure, many are over 70%.





*Approximate based on CY2023 data, the point is it's roughly in proportion to total beds owned.

Skilled Nursing Facilities (SNFs):

Vermont has reduced SNF beds over the last decade, while our older population has grown.

In the last 10 years, 6 facilities have closed, and 8 have reduced their number of licensed beds.

Our SNF coverage is very thin when reviewed for geographical distribution.

Two counties have no SNFs, three counties have only one option. Six counties rely on one provider for 50% or more of the bed access.

If closures continue, we are at risk of losing access entirely in some regions.

County	Medicare Population	# Facilities	# Beds	Concent-ration	Beds to People*
Addison	9,129	1	98	100%	11
Bennington	10,256	3	311	42%	[1]
Caledonia	7,992	2	159	61%	5
Chittenden	32,579	4	493	27%	7
Essex	1,984	0	0		
Franklin	10,694	3	187	50%	[6]
Grand Isle	2,167	0	0		
Lamoille	5,623	1	72	100%	9
Orange	7,577	1	30	100%	12
Orleans	7,803	4	203	35%	[3]
Rutland	17,632	3	386	41%	4
Washington	14,844	4	414	37%	2
Windham	12,303	3	183	44%	8
Windsor	16,681	3	181	53%	10

*County ranking on bed availability compared to population, bracketed ranks are counties serving neighboring counties that have no SNF.

Goals for FY2025 Budget:

- Stabilize the SNF sector to ensure Vermont does not move backwards in access to medical care. We cannot afford to take more beds offline, whether through loss of licensed beds / facilities or (as we've seen recently) the inability to fully staff.

- Move away from Emergency Financial Relief-based adjustments for individual facilities at risk of closure. We need a SNF rate methodology that ensures appropriate payment across the sector.
  - At the same time, keep investments that are *appropriate* as one-time support as single investments.

- Reduce stressors on the broader health care system created by constrained SNF capacity.
  - This goal includes both basic access and services for complex care patients.

Goals for FY2025 Budget – Governor's Proposed Budget:

The Governor's proposed FY25 Budget, and FY24 Budget Adjustment Act, include three primary structures for achieving the broader goals for SNFs:

- Rate Restructuring - $9.9 million
  - Occupancy Threshold Drops to 80%
  - Adjustments to Median & Percentile Caps for Workforce

- Extraordinary Financial Relief – BAA Request
  - Limited time investments for individual facilities that are at danger of closure, calculated as an enhanced Medicaid payment to cover costs. FY23 Requests totaled $18 million ($13 million granted).

- Complex Care in the iCare Facility - $2.5 million for Incentive Rates
  - Plus a base + transition rate cost of $2.26 million

VHCA Request for SNFs in FY2025 Budget:

We are concerned that the budget as structured is not sufficient to achieve stabilization.

- **Nursing Workforce Costs**: The changes made solve a problem for payment to hospital-affiliated SNFs, but other facility types also need support to bring Medicaid payments closer to their actual workforce costs.

- **Other Workforce Costs:** Most SNF staff outside of nurses are paid based on cost data that is reviewed every 4 years, plus an 18-month delay for audits. This means that by the end of a cycle, the original data is almost 6 years out of date. Impacted staff positions include key personnel like Medical Directors and mental health providers.

- **2021 Occupancy Anomalies:** 9 providers had very low occupancy in calendar year 2021 due to COVID-19 related disruptions and have since recovered, but will be carrying a large penalty until the FY28 rebase.

The appendix pages provide more details.

Appendix Slides

VHCA Request for SNFs in FY2025 Budget – Estimated Costs:

- **Nursing Workforce Costs:** Based on 2022 Cost Data and Balance Sheet Reviews for the BAA, VHCA estimates a need for $17 - $20 million (gross) for workforce.
  - Some of this amount is already covered in the Governor's proposal.
  - Some is workforce other than nurses.

  Estimated additional need is ~$9 million to bring facilities back to average capacity.

- **Other Workforce Costs:** We request the state review an updated system for more frequent rebasing of workforce costs and systems for adjusting workforce to match residents' direct care needs.
  - As described in following slides, some positions covered in these "other" categories are crucial to continued operations and may require financial relief before the next rate methodology update. Estimate of $1 million.

- **2021 Occupancy Anomalies:** Using the greater of CY2021 occupancy or 12-month current average would cost ~$4 million. Restricting to facilities with a 10% or more discrepancy (ie truly anomalous) reduces cost to $1.6 million.

Rate Methodology for Nursing Workforce:

SNF Reimbursement for Long Term Care Medicaid stays is a cost-based per-diem. The overall per diem is composed of different cost centers that are calculated in different ways.

The largest clinical staff component for SNFs is nursing. These costs are calculated every 2 years from audited cost reports. There is an 18-month delay for desk review, meaning that costs are always 2-3 years in the past. DVHA uses a standard inflation index to increase nursing reimbursement from the base year to the current year.

This system does not work well with high volatility in labor costs, when contracting structures change, and/or when providers need to re-balance their staffing structure – for example, making investments to reduce reliance on contract staff or changing staff ratios to comply with new regulations.

Nursing workforce costs have also had a cap at 90th percentile. Hospital-owned SNFs have different workforce structures than other SNF types, and consistently exceed this cap. The state has proposed shifting to 95th percentile, which would remove most of the extra costs hospitals have carried for nursing due to the cap. It does not impact other SNFs.

[Nursing costs also include a case mix adjustment that is currently being updated; that change is budget neutral and not discussed here]

Rate Methodology for Nursing Workforce:

The lag times for updating SNF nursing costs are having a significant negative impact.

- A simplified way to evaluate statutory inflation is through what cost reports tell us it needs to be more than. The increase of actual nursing cost from 2021 to 2022 was 17.4%. To project 2021 costs to an accurate FY2025 level requires more than 17.4% inflation because it is a longer period.

- By 2022, the costs of contract nursing exceeded that of permanent staff at SNFs (statewide average). We do not have 2023 cost data, but we know that Vermont SNF dependence on agency nurses remained around 30% from 2022 through 2023 so we can anticipate ongoing elevated costs.

- SNFs requested $18 million in EFR support in 2022, primarily to alleviate workforce costs. $13 million was granted. These EFRs were calculated simply to close the gap between Medicaid rates and actual costs; they did not include stabilization investments, such as improving pay to help retain / attract permanent nursing staff. The EFR rules are not structured to be applied in that way.

- Facilities can only apply for EFR when they have exhausted other options for covering revenue shortfalls. When the external forces making EFRs necessary are sector wide, as they are now, EFR pressure will grow as more providers exhaust other funding sources and become eligible.

Rate Methodology for Resident & Direct Care Staff:

Personnel costs covered in Resident and Indirect Care are rebased every 4 years. With additional time for auditing, this schedule means that a rate paid at the end of a cycle may reflect workforce structures that are 6 years out of date.

Positions in Resident and Indirect costs include:

- Medical Director
- Pharmacy Consultant
- Geriatric Consultant
- Psychological / psychiatric consultant
- Counseling personnel
- Social Workers
- Activities personnel, including recreational therapy
- Chaplains
- Art Therapists
- Feeding Assistants
- Food service staff
- Housekeeping

Resident and Indirect costs are also subject to payment caps, calculated at Median + a certain percent.

As with nursing, this reimbursement system assumes stable costs. The effects are more complicated in this case because (unlike nursing) these components of the rate combine both staff positions *and* other types of costs, such as utilities payments, that may be more stable and reasonably calculated with an annual inflation.

Rate Methodology for Resident & Direct Care Staff:

Nursing costs receive attention as the largest driver of current reimbursement shortfalls in total dollars. However, these other cost centers include "keystone" staff positions that are necessary for stabilizing SNF capacity and maintaining operations until the next rebase:

- Medical Directors are required in SNF licensing regulations, so all facilities need to have continuous Medical Director coverage. Medical Directors play critical roles for patient admissions, coordination with local physicians for services, and overall clinical quality. SNFs are particularly vulnerable for Medical Director coverage because they do not directly employ physicians. Their contracting structures for Medical Directors have changed substantially since 2021.

- Staff providing direct care to residents with more-complicated care needs – for example, feeding assistance to complement SLP services, non-nursing direct care support for residents with dementia, mental health consultants. Many of the barriers to patient placements in SNFs involve not just a lack of nursing staff, but also an inability to support patients' comprehensive care plans.

Because lack of a Medical Director is existential for SNFs, VHCA estimates for needed funds in FY2025 focused on that role, but achieving system stability requires a new approach to critical staff costs that do not fall under the nursing category.

Revenue Shortfalls Entering FY25 and EFRs:

Shortfalls in Vermont SNF operating revenues compared to actual costs have risen significantly. In 2018, there was a shortfall of $4.6 million, rising to $4.9 million in 2019. By contrast, in 2021 the shortfall was $32.3 million, rising to $46.2 million in 2022.

In 2022, COVID-related funds were available to help offset the $46.2 million gap and this is shown by a lower EFR request amount in that year. By 2023 those other sources had ended and the state saw almost $20 million requested.

Years of successive revenue shortfalls have diminished facility reserves that might have helped smooth financial problems, such as volatility in workforce costs.

Workforce costs are the primary driver of these financial problems. Prior to the pandemic Vermont was slightly better than average in SNF workforce stability. We are now the *least* stable state. Use of nursing agency staff remained at nearly 30% average throughout 2023, higher at LPN and LNA levels. Loss of Medical Director contracts with local medical groups further exacerbates staffing problems.

The outlook for FY2025 suggests continued workforce challenges. Proposed federal regulatory changes, proposed state changes to workforce requirements in residential care, and ongoing national workforce shortages indicate a continued period of instability at a time when facilities have minimal reserves.

Revenue Shortfalls Entering FY25 and EFRs:

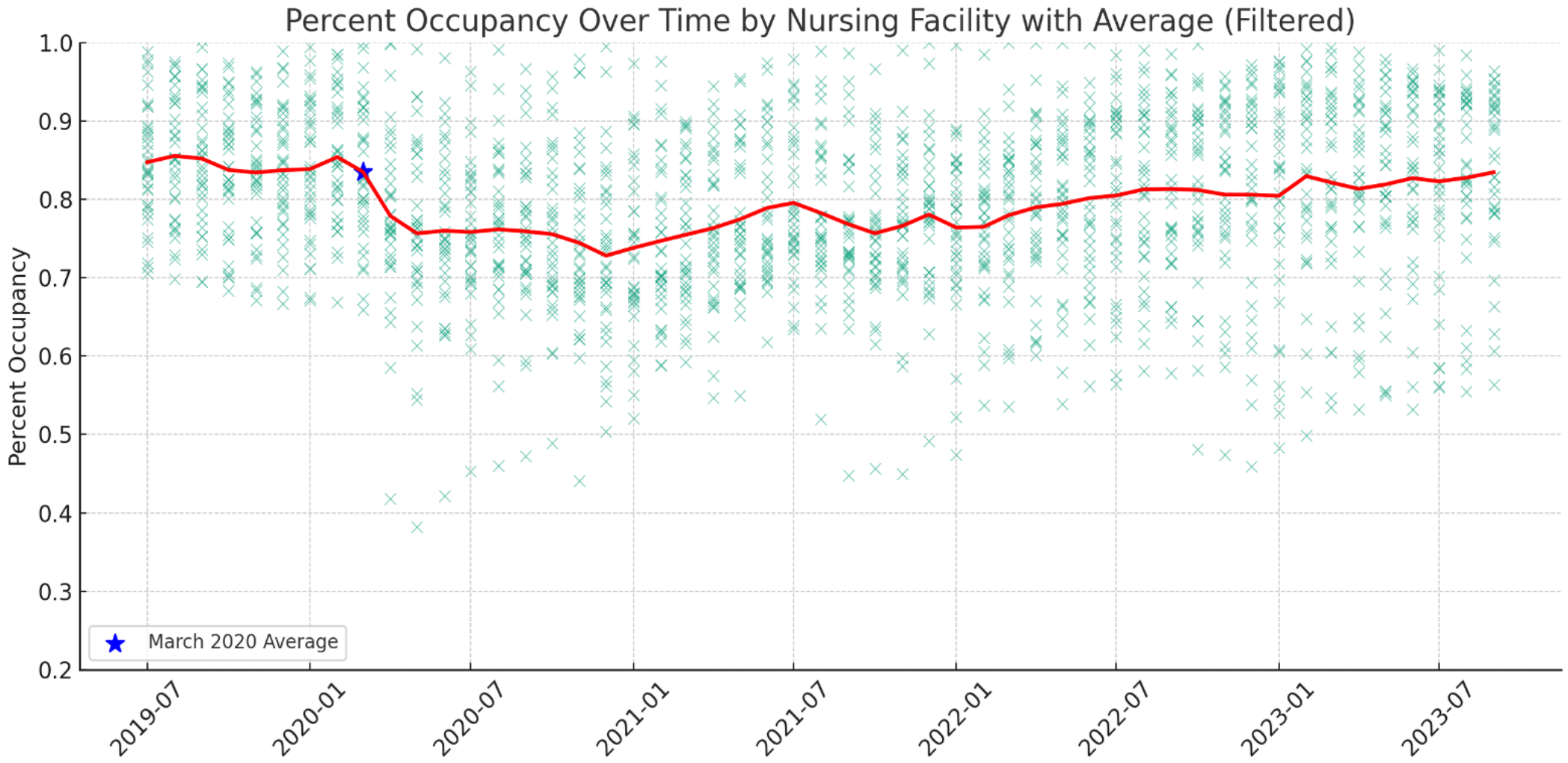
Current needs for FY24 EFR are addressed in the Budget Adjustment Act. The proposed FY25 budget addresses some of the underlying problems that have led to a need for assistance, but it has not closed the considerable shortfall in workforce costs.

The EFR tool has been a powerful way for the state to maintain SNF access during recent disruptions. However, this tool is designed to be a temporary bridge, not to proactively cultivate stability.

We provided one example in the nursing costs – EFR covers current costs, but it does not shift the structure of staffing to reduce future costs. It is designed to be responsive to external financial pressures that are temporary in nature. The workforce pressure has now extended multiple budget cycles.

Another constraint is that EFR is calculated for individual facilities who submit detailed applications that receive close review. It does not offer a way for rate setting to correct a sector-wide problem in reimbursement that falls outside the rate methodology.

An example of this problem is the underpayments for facilities that had abnormally low occupancy in 2021 due to COVID-19 disruptions. Updating the occupancy threshold to 80% alleviates some of that cost, but still does not reverse an unfair financial penalty that will last 4 years. (See next slide for details).



Average occupancy has returned to low 80%. However, the range of occupancy levels is greater than pre-pandemic. There is limited capacity at both ends of that range. For facilities that recovered their capacity after the pandemic, some will be carrying a financial penalty for 4 years, reflecting low occupancy in 2021. 9 facilities had a 2021 CY occupancy under 80% and more than 10% lower than current average occupancy. These facilities will carry a combined $1.6 million financial penalty until FY2028.