Helen Labun, Executive Director

hlabun@vhca.net | vhca.net

January 21, 2026

Members of VHCA

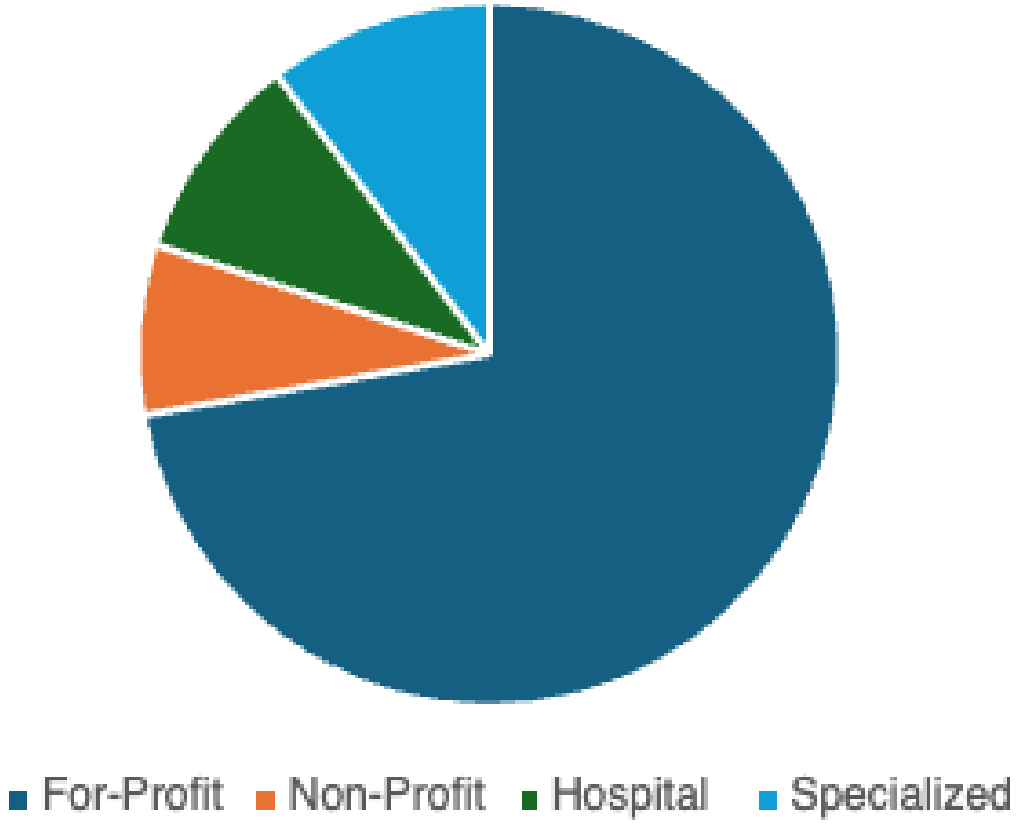
- Nursing Facilities / Skilled Nursing Facilities (SNF)
- Residential Care Homes (RCH)
- Assisted Living Residences (ALR)

These providers all offer forms of residential long-term care, and some offer short- term rehabilitation care.

Each have different considerations for who they serve, what services they offer, how they are regulated, and how they are paid.

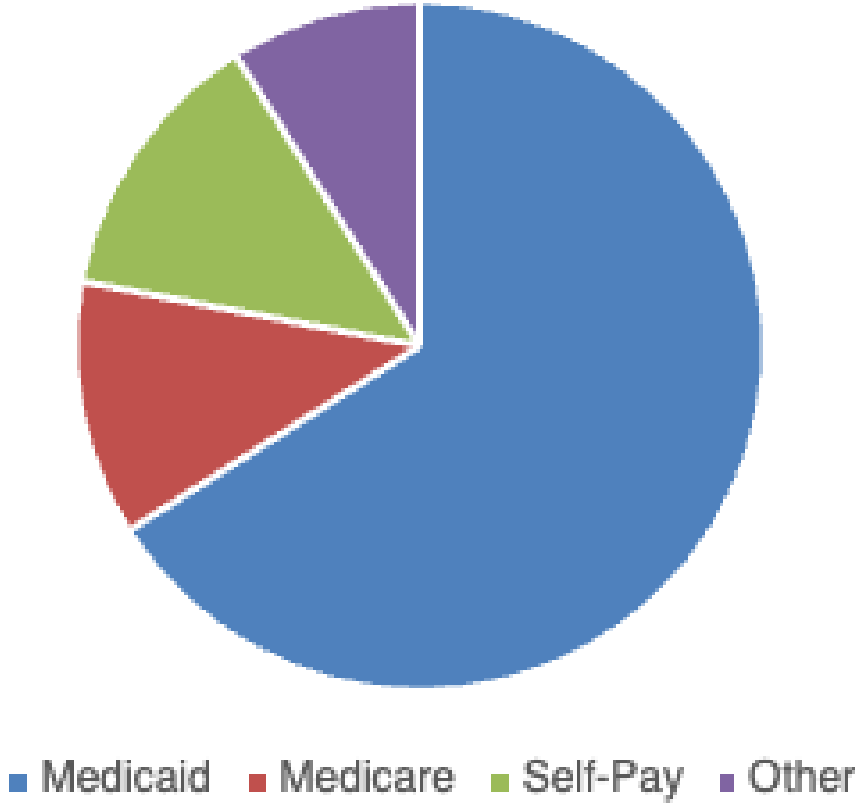
This presentation is focused on nursing homes and sector characteristics relevant to VHCA's written testimony on H. 583

Nursing Home Capacity in Vermont



Licensed Beds (~2,900) by Structure

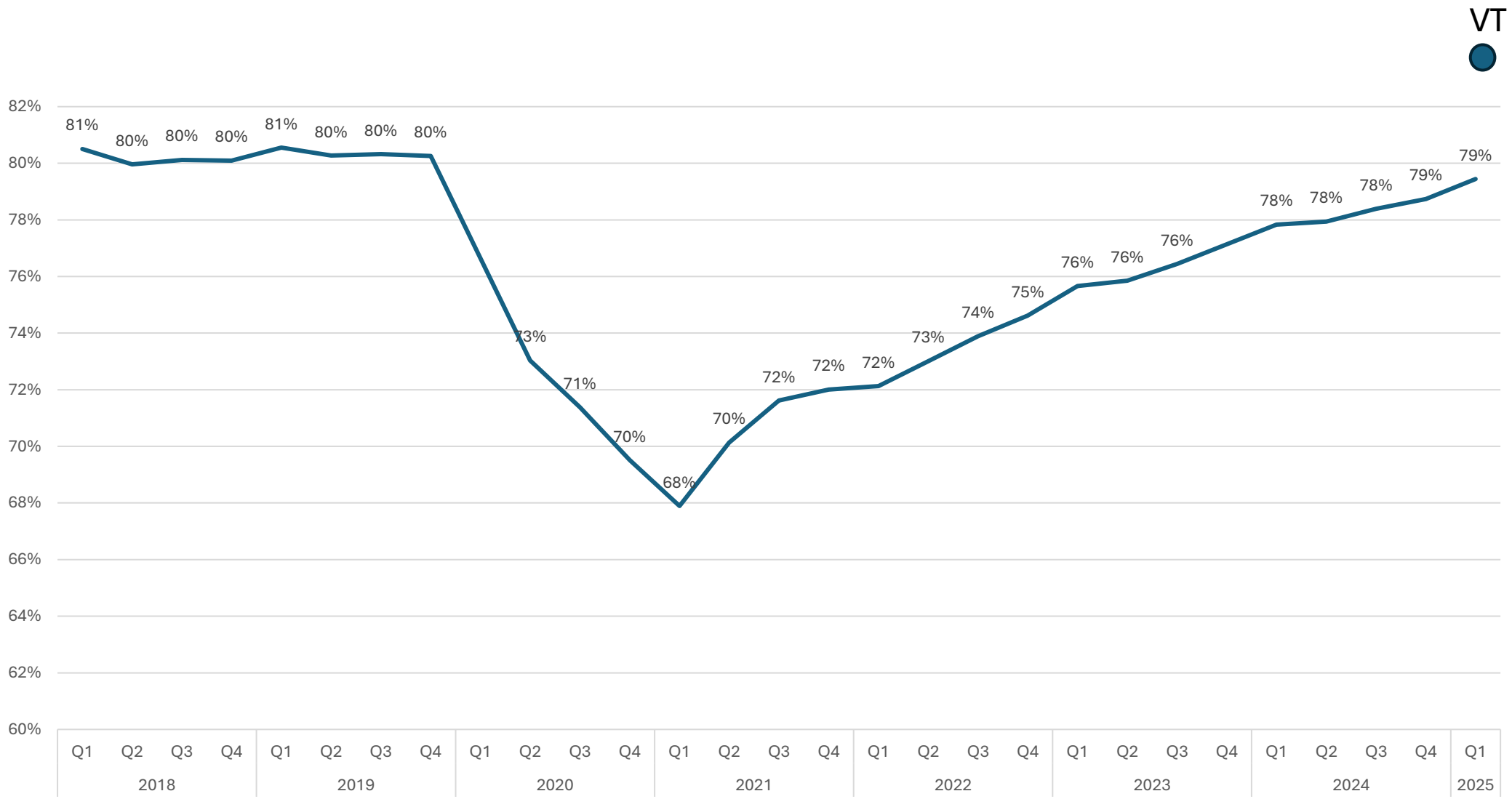
"Specialized" includes Veterans Home (public), Wake Robin (CCRC), MissionCare (for-profit special contract)



Utilized Beds by Payer

"Other" includes VA and hospice

Nursing Home Capacity in Vermont



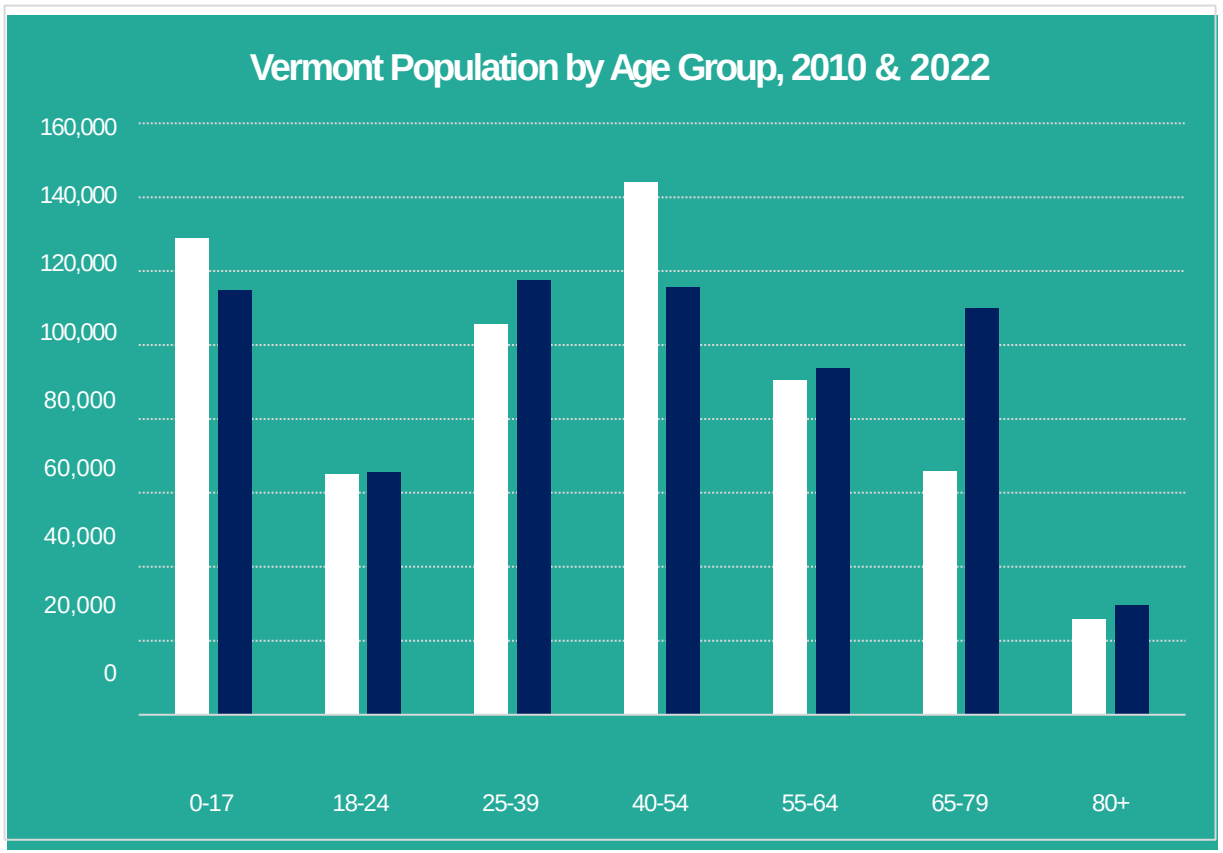
Nursing Home Capacity in Vermont

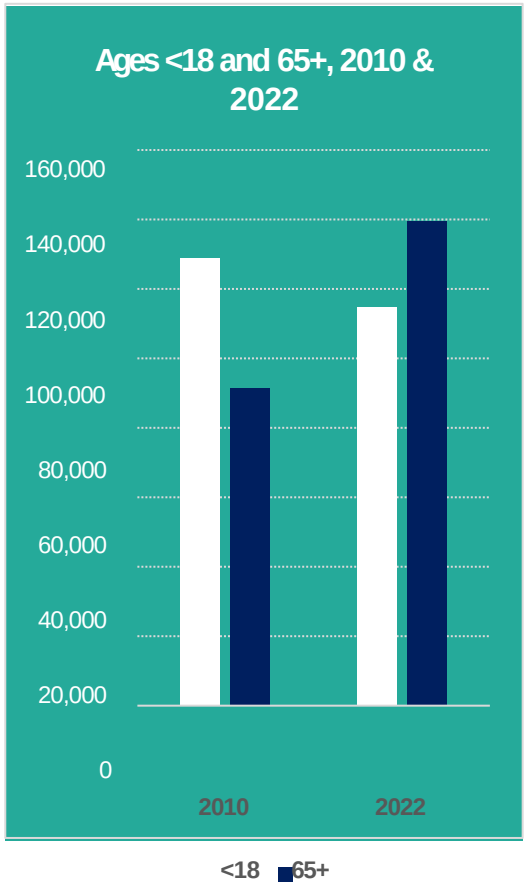
“Full” census doesn’t mean 100% of licensed beds:

- Some beds are for short term rehab, which has high turnover and also a seasonal element (e.g. slipping on ice)
- Rooms may be licensed for multiple beds but not used that way – for example, infection prevention protocols, resident conditions that require no roommate, family privacy at the end of life, legacy licenses for old configurations
- Nursing homes will slow down or pause admissions for a variety of reasons – for example, renovations, key staff transition, new unit licensing, flu or COVID outbreak

In spite of significant workforce shortages, Vermont’s census is robust.

Nursing Home Capacity in Vermont





Source: U.S. Census Bureau, Estimates based on 2010 Decennial Census and 2022 Population Estimates

- Age is the top predictor of requiring nursing home care.
- In 2010, there were more people under the age of 18 in Vermont than there were over the age of 65.
- In 2022, the opposite was true. And the 65+ age categories are the fastest growing.

Nursing Home Capacity in Vermont

Other considerations around capacity:

- Two counties have no nursing homes, three have only one
- Many current independent owners are at, or past, their planned retirement age
- Many buildings need to be upgraded to reflect current standards for nursing home care – no triple & quad licenses, new approaches to memory care configuration, need to offer services like dialysis

Vermont cannot lose many more nursing home beds and will likely need to gain capacity soon to match demographic trends.

VHCA’s written testimony explains why we believe § 9521 (Definitions) and § 9525 (Prohibited Transactions) cut off access to ordinary, stable, and necessary financing and contracting relationships across the sector.

The operational impact will be a reduction in our already strained capacity to provide residential long-term care services.

Some Important Regulatory Distinctions

- Skilled Nursing Facility regulations are set primarily by the federal government with states performing inspections under federal contract.

- Unlike some forms of hospital & primary care services, there is a strong regulatory emphasis on not accepting referrals if a SNF cannot guarantee an ongoing ability to provide the services in the individual care plan.

- Regulations also prevent low-acuity admissions. This is accomplished through detailed resident assessment requirements that both establish need for nursing home care and reduce the entire per diem rate when a facility has lower-acuity residents.
  - Vermont has bolstered this element of the SNF expectations by investing in Assisted Living and Residential Care Homes as an alternative.

VHCA’s written testimony explains why § 9525 (Prohibited Transactions) creates obligations at the state level that are disallowed under federal regulations.

Some Important Regulatory Distinctions

- When a facility wants to change ownership, there is an extensive application and review process through the Agency of Humans Services Department of Disabilities, Aging, and Independent Living.
  - This process moved from GMCB to Division of Licensing & Protection in 2018
  - The application process for a transfer of ownership was updated in Vermont last year

- CMS reviews ownership changes for Medicare enrollment, plus enforces its own set of ownership transparency & financial disclosures

- Additional reporting on financial arrangements, including costs, related entities, and audited financial statements, go to:
  - DVHA Division of Rate Setting (Vermont)
  - DAIL (Vermont)
  - CMS (Federal)

VHCA’s written testimony explains why § 9541 (Reporting of Ownership and Control) and § 9542 (Sharing of Ownership Information) is duplicative. “Duplication” in this case includes concerns about different time schedules, reporting platforms, and interpretations that make the process unnavigable.

VHCA’s written testimony explains why § 9547 (Enforcement of Chapter) does not match existing regulatory structures and creates layers of scattered effort.

Workforce Shortages

- SNFs are required to have physician coverage as Medical Director and for regulatory rounds, but SNFs do not directly employ physicians.

- Lack of available primary care physicians in Vermont plus regulatory changes to the structure of the Medical Director and rounding physician roles have led to insufficient physician access.
  - This does mean “physician” – some of the activities included could be performed by Nurse Practitioners under state rules, but not federal rules.

- The Vermont Legislature provided funding to study and address the Medical Director shortages in Vermont in FY2025. Among other findings, about half of nursing homes have unstable coverage.
  - Unstable can mean temporary contracts, high turnover, anticipated retirement without identified replacement, or a citation for insufficient coverage.

VHCA's written testimony explains why § 9531, § 9532, § 9533 (Corporate Practice of Medicine) serves primarily to reduce access to qualified physicians.

VHCA endorses an approach to Corporate Practice of Medicine regulations that focuses on clinician autonomy and prohibiting corporate interference in clinical decision making.