SFY 2026 BUDGET
HOUSE HEALTH CARE

February 19, 2025

Care at Home, Across the Continuum

Health Care	Prevention	Long-Term Care	End-of-Life and Palliative Care
Nursing and Therapy	Health Screenings and Vaccinations	Pediatric and Adult High-tech	Palliative Care
Telemonitoring	Maternal/Child Health	Personal Care	Hospice Care
Wound Care		Homemaker services	Bereavement Services
Care Coordination		Case Management	Respite House

Critical Role in Health Care System

- Serves vulnerable population of frail, older and disabled people with numerous chronic conditions
  - 86% of Vermont Medicare beneficiaries who use home health have 3 or more chronic conditions vs. 9% of all Vermont Medicare beneficiaries
- Accepts 14% of discharges
  - Nursing homes accept about 18%
- Reduces pressure on hospitals and long-term care facilities

Pressures

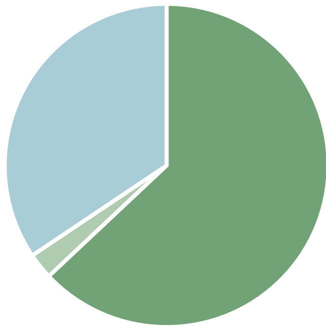
- Cost of travelers
- IRS mileage rate
  - Up 12.5 cents per mile/22% since 2020)
  - No direct payments to home health agenices for mileage
- Workforce shortages
- Wages, salaries and benefits
- Historically low Medicaid reimbursement and inconsistent rate increases, particularly for long-term care services

Pressures (continued)

- Medicare margins no longer available to support losses in other programs
  - Migration to Medicare Advantage
  - Permanent Medicare cuts moving to 10.77%
    - January 1, 2023: 3.925%
    - January 1, 2024: 2.890%
    - January 1, 2025: 1.975%
    - Expected January 1, 2026: 1.975%
  - Phased-in rollout of the total cut increases the risk of a large clawback – authorized for total cut back to January 1, 2020

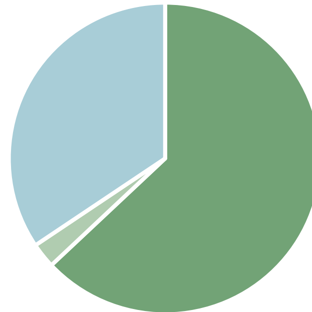
Pressures: Medicaid

Most Profitable



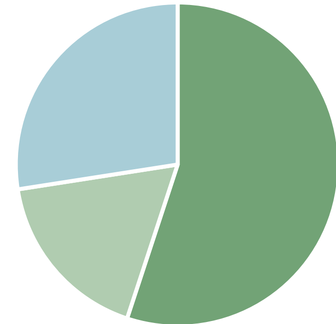
■ Medicare ■ Medicaid ■ Other/MA

New England



■ Medicare ■ Medicaid ■ Other/MA

Vermont



■ Medicare ■ Medicaid ■ Other/MA

SFY 2026 Budget Request

- Bring home health to 90% of Medicare rates, currently at 67% - approximately $1.2 million in General Fund dollars
  - Includes commensurate increases to pediatric palliative care and high technology services
  - New rate methodology compares our per-visit Medicaid fee schedule to the episodic Medicare fee schedule

Patient-Driven Groupings Model

- Medicare
  - 30-day periods for low-visit episodes
  - 432 case-mix groups based on admission source, timing in the 30 days, clinical groups, functional impairment, "co-morbidity" i.e., other diagnoses
  - "Value-based payment" potential (upside and downside)
  - Low Utilization Payment Adjustment (LUPA)
    - Per visit rate for low-visit episodes
- Medicaid pays on a per-visit basis