REPORT TO THE VERMONT LEGISLATURE

Agency of Human Services
280 State Drive
Waterbury, VT
www.humanservices.vermont.gov

[phone] 802-241-0440
[fax] 802-241-0450

Department of Vermont Health Access
Report on Nursing Home Extraordinary Financial Relief

In accordance with Act 27 of 2025, Sec. E.306: An act relating to making appropriations for the support of government.

Submitted to: House Committee on Human Services
Senate Committee on Health and Welfare

Submitted by: DaShawn Groves, Commissioner
Department of Vermont Health Access

Prepared by: Jaime Mooney, Director of Rate Setting
Department of Vermont Health Access

Alicia Cooper, Director of Managed Care Operations
Department of Vermont Health Access

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EXECUTIVE SUMMARY

Vermont's nursing homes are increasingly experiencing financial distress at a time when capacity is essential. Extraordinary Financial Relief (EFR) provides financial assistance to nursing homes that experience severe, unexpected fiscal distress and are at risk of closure or service disruption. Following the public health emergency, EFR requests have increased both in frequency and in total dollars awarded. This trend reflects pressures facing Vermont nursing homes, including persistent workforce shortages, increases in contract staffing costs, inflationary pressure on food and utilities, and the time between the base year costs and the rate year of the reimbursement based on these costs. This report summarizes both direct and indirect strategies that could be considered for improving the financial position of Vermont's nursing homes.

The Department of Vermont Health Access (DVHA) and the Department of Disabilities, Aging, and Independent Living (DAIL) propose to engage in stakeholder engagement with key partners around each of the following Medicaid rate setting policy options as part of the Agency's broader, ongoing work to plan for the sustainability of Vermont's long-term care system, (which also includes efforts to address workforce constraints and efforts to build additional system capacity serve more Vermonters and address more complex future needs):

- aligning rebasing of Resident Care, Director of Nursing, and Indirect components on a two-year cycle and/or rebasing Nursing Care costs annually;
- establishing higher per diem limits on costs for specific peer groups of nursing homes (e.g., facilities with 40 or fewer beds); and
- reviewing the Step-Up process to eliminate or adjust the current 12-year ownership requirement, allowing greater coverage of interest and depreciation costs, and relying solely on the Construction Index, a measure that better reflects building values during ownership transitions.

Additionally, DVHA and DAIL will implement the following beginning in 2026:

- launching resident case-mix validation audits with an associated provider education period; and
- implementing provider trainings on special rate requests and mid-year rate adjustment procedures.

Workforce shortages, agency staffing costs, and demographic changes will continue to challenge providers, but these potential adjustments could directly address the limitations

in Vermont Medicaid rate setting that contribute to recurring EFR requests. EFR would remain available as a safety net, but these potential policy changes could make its use less frequent, less urgent, and more predictable.

STATUTORY CHARGE AND INTRODUCTION

STATUTORY LANGUAGE

Act 27 of 2025, Section E. 306: NURSING HOMES: SKILLED NURSING FACILITIES: EXTRAORDINARY FINANCIAL RELIEF

(a) On or before December 15, 2025, the Department of Vermont Health Access' Division of Rate Setting shall submit a report to the House Committee on Human Services and to the Senate Committee on Health and Welfare containing proactive measures and targeted interventions that may be used to reduce the use and amount of future extraordinary financial relief for nursing homes.

INTRODUCTION

Vermont's nursing home system comprises 33 Medicaid-enrolled facilities with 2,847 licensed beds, ranging from smaller local homes to larger hospital-related facilities. Pre-pandemic average utilization was 83 percent. Utilization declined during the pandemic but returned to 80 percent in August 2022 and has continued to increase, now exceeding pre-pandemic levels. Operating costs have risen due to workforce shortages, higher wages, and increased reliance on contract staff, with expenses outpacing general inflation across all cost categories. These factors have contributed to increasing fragility of the nursing home system in Vermont. Homes are increasingly experiencing financial distress at a time when capacity is essential.

It is critical that Vermont strengthen the long-term care (LTC) system, from home- and community-based options to skilled nursing facilities, to meet the changing needs of Vermont's aging population. A strong and stable LTC system, with increased access and capacity to address complex needs is dependent on having a robust workforce to meet this demand and the financial stability to expand LTC options. Recognizing that workforce is key to nursing home stability, DAIL is working closely with providers on key initiatives, including: 1) Grants to nursing homes to increase recruitment and retention of Licensed Nursing Assistants (LNAs). These grants, funded through a SFY26 legislative appropriation, are designed to test innovative models for recruitment and retention with a goal of building a more sustainable workforce; and 2) Partnership with the Centers for Medicare and Medicaid Services (CMS) on a nursing home staffing campaign that utilizes a combination of state and federal Civil Monetary Penalty (CMP) funds to support RN and LPN recruitment and retention over several years, with funds to be used for tuition assistance or loan

forgiveness for nurses working in Vermont nursing homes. DAIL and DVHA are working together to strategically plan for long-term sustainability through a multi-year, multi-pronged approach to address capacity, financial stability, workforce, quality, and complex care.

Vermont's nursing home Medicaid rates are set through a cost-based methodology with components that are rebased on different cycles: Nursing Care every two years; Director of Nursing, Resident Care and Indirect every four years; and Property and Ancillary annually. This structure was established in 2007, when nursing home costs were more stable. More recent updates include a transition to the methodology used for case-mix adjustment and the July 1, 2024 changes that increased cost caps and lowered the minimum occupancy requirement from 90% to 80%. As agency staffing costs rise, expenses outpace the inflation factor, and smaller and hospital-related facilities more frequently exceed cost caps, additional updates to the methodology may be necessary to better align rates with current operating conditions. Additionally, existing opportunities for providers to seek increased reimbursement, such as special rates for Unique Physical Conditions and Unique Mental and Emotional Conditions, are underutilized. Expanding training and guidance may help providers understand and access these adjustments, supporting improved financial stability.

Extraordinary Financial Relief (EFR) provides financial assistance to nursing homes that experience severe, unexpected fiscal distress and are at risk of closure or service disruption. EFR is not an entitlement; it is reserved for situations where financial hardship would threaten resident care and no other remedies are available. Increased reliance on EFR is a symptom of the financial fragility of Vermont's nursing home system of care. Reducing the use of EFR is not a goal unto itself, but achieving less reliance on EFR would signal improvements in system stability, which *is* the broader goal.

Following the public health emergency, EFR requests have increased both in frequency and in total dollars awarded. This trend reflects pressures facing Vermont nursing homes, including persistent workforce shortages, increases in contract staffing costs, inflationary pressure on food and utilities, and the time between the base year costs and the rate year of the reimbursement based on these costs. Because nursing home rates are based on historical cost reports, a two- to four-year delay can separate the financial data used for rate setting from the actual fiscal conditions faced by providers.

The Division of Rate Setting ("The Division") reviewed recent EFR requests, nursing home cost report data, and Medicaid rate setting provisions to identify targeted interventions that

could reduce future reliance on EFR. This report summarizes both direct and indirect strategies that could be considered for improving the financial position of Vermont's nursing homes.

ANALYSIS OF EXTRAORDINARY FINANCIAL RELIEF TRENDS

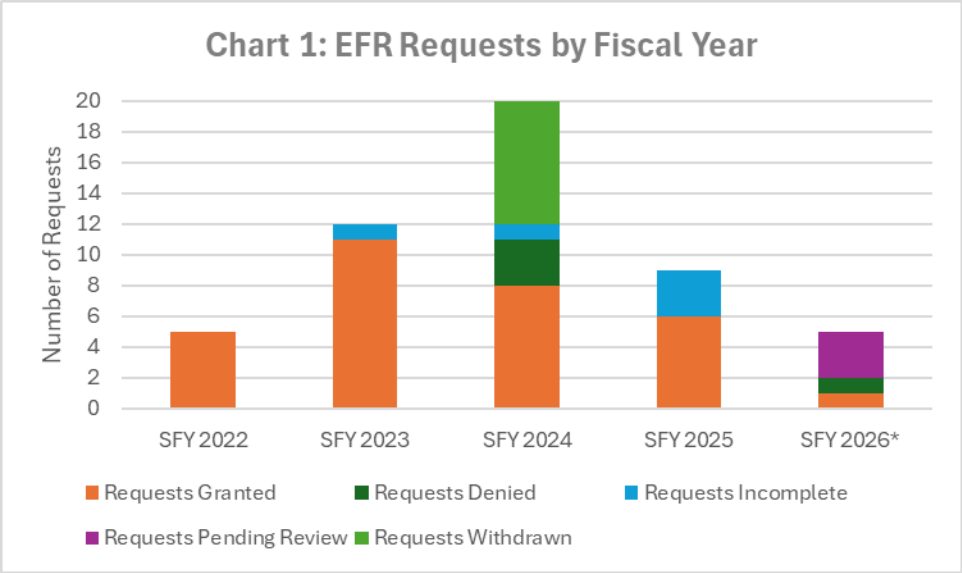
WHAT IS EFR AND WHEN IS IT USED?

EFR funding is awarded when a facility demonstrates imminent financial risk that threatens its ability to continue operations and to provide adequate resident care. Requests are evaluated by the DVHA Division of Rate Setting in collaboration with DAIL. Rate Setting verifies financial need and determines whether existing rates are sufficient to cover allowable costs. DAIL staff confirm compliance with Medicaid participation requirements and certify that the nursing home beds at homes requesting EFR are necessary to the system of care.

HISTORICAL OVERVIEW AND FINANCIAL TRENDS

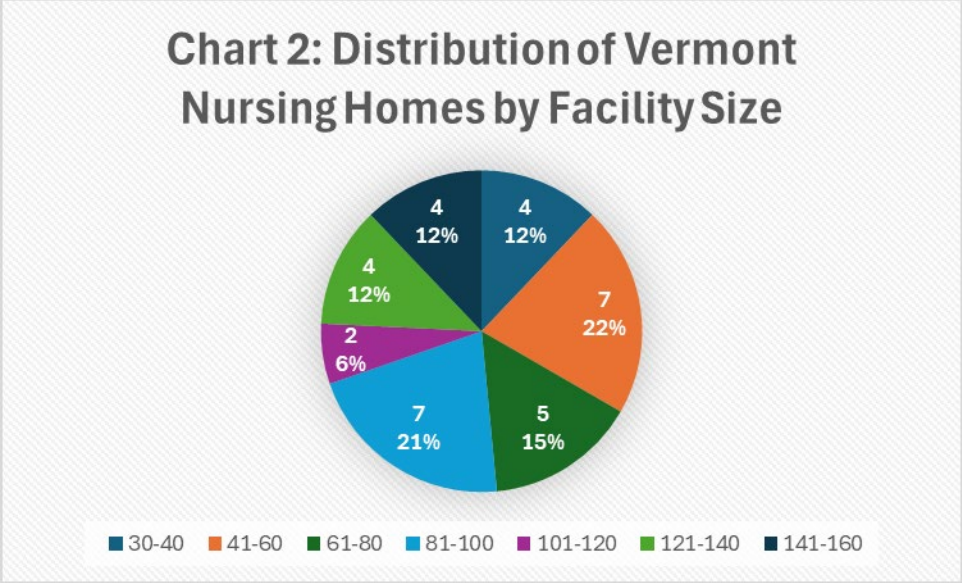
From SFY 2022 through SFY 2026, Vermont nursing homes submitted a total of 51 EFR requests. The distribution of requests over time illustrates both systemic and acute pressures on the nursing home sector. In SFY 2022, five requests were submitted and all were granted. SFY 2023 included 12 requests, 11 of which were granted and one classified as incomplete when the nursing home did not provide the requested information. In SFY 2024, 20 requests were submitted: eight were granted, three were denied, one was incomplete, and eight requests were withdrawn. In SFY 2025 there were nine requests, six were granted and three were deemed incomplete.

As of December 1, 2025, midway through SFY 2026, there have been five additional requests. Of these, one has been granted, one has been denied, and three remain pending. The partial-year data suggest that EFR demand remains elevated, continuing a post-pandemic pattern of increased fiscal distress among nursing homes.



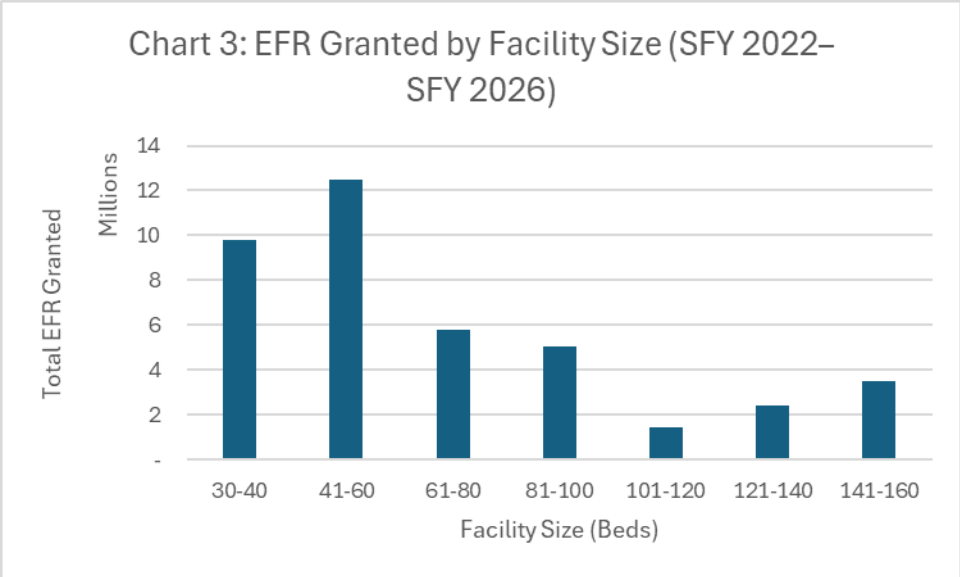
Data from Vermont nursing home EFR Requests; see Appendix 1 for full underlying data.
**SFY 2026 data cover the first 5 months of the fiscal year; figures are current as of 12/1/2025 and do not represent the full year.*

Circumstances contributing to the need for EFR are unique to each facility that applies. However, common drivers of recent requests are: (1) labor cost escalation, often driven by reliance on agency staffing; (2) structural Medicaid underpayment resulting from the lag between base-year cost data and current operational costs; and (3) rate volatility tied to case mix scoring changes and documentation inconsistencies.



Smaller facilities are overrepresented among EFR applicants because their higher per-diem costs frequently exceed statewide caps. When caps are based on averages from all facilities, including larger homes with lower per-diem costs, smaller homes are disproportionately pushed over the limit and therefore may require more EFR support because fewer of their costs are covered by their Medicaid rates.

Key observations from the review of recent EFR requests include: (a) rebasing using cost report data two or more years old failed to capture rapidly rising labor and agency costs, creating funding gaps; (b) small homes with lower census face higher per-day costs that are frequently constrained by existing cost caps; and (c) several EFR requests specifically cited Patient-Driven Payment Model (PDPM)-related reductions in the nursing component as a proximate cause of cash shortfalls. PDPM is a Medicare case-mix classification model.



Data from Vermont nursing home EFR Final Orders; see Appendix 1 for full underlying data

ANALYSIS OF POTENTIAL PROACTIVE MEASURES

The Division has identified a range of proactive measures that could be considered to reduce the need for EFR and strengthen the long-term financial stability of Vermont nursing homes. These recommendations fall into two broad categories: (1) measures that could directly and materially reduce EFR demand, and (2) system-level initiatives that could enhance financial predictability for providers and ensure that cost reporting and

administrative processes are clear, well-aligned with policy, and easy to navigate. Together, these efforts aim to create a more stable operating environment and reduce the likelihood that facilities will experience unexpected fiscal pressures.

Measures That Directly Reduce EFR Need

A. Adjusting Cost Caps for Peer Groups

A possible option for modifying the Medicaid nursing home rate setting methodology involves reviewing and adjusting cost caps for nursing homes across different facility peer groups, such as 30-40 bed facilities, 41-60 bed facilities and hospital-related facilities. Vermont's current cost cap formulas, as outlined in the Provider Manual[1], treat all facilities uniformly and do not adequately account for fixed costs that small providers must distribute across fewer resident days, nor the higher operating costs typically associated with hospital-related facilities. If changed, this would directly result in greater allowable cost coverage through the Medicaid reimbursement and would primarily benefit the homes that have sought EFR in recent years. This adjustment would also increase coverage for expenses such as Medical Director costs, which have risen substantially in recent years. As detailed in Appendix Tables 1 and 2, small homes and hospital-related facilities exceed cost caps at higher rates in both Resident Care and Indirect cost components, which helps explain their more frequent reliance on EFR.

The current structure disproportionately constrains reimbursement for smaller facilities, which are often more vulnerable to occupancy fluctuations and must often pay their Director of Nursing and administrator at the same rate as the larger facilities. Hospital-related homes are also affected, not because of size, but due to higher operating costs associated with being linked to a hospital. The Division could revise the cost cap methodology to allow higher per diem costs for small homes and elevated costs for hospital-related facilities, and increased coverage for Medical Director costs. By ensuring more equitable reimbursement, this measure would reduce chronic underpayment and potentially lower the frequency of EFR requests among these providers.

B. Rebasing Cost Components Using More Current Data

The Division of Rate Setting uses a methodology for setting nursing home rates that requires periodic rebasing of the various nursing home cost categories. When the methodology was developed in 2007, nursing home costs were generally stable, meaning

[1] https://dvha.vermont.gov/sites/dvha/files/documents/NursingFacilityProviderManual.pdf

rebases were not needed as frequently to ensure that rates were somewhat consistent with costs. Within the last several years, nursing home costs have been much more variable year-to-year, particularly in areas such as contract nursing costs and Medical Director costs, which change frequently. Therefore, a potentially significant change could involve updating the frequency and methodology used to rebase cost components in Medicaid rate setting with the goal of shortening the gap of time between the costs on which the Medicaid rates are based and the period in which Medicaid rates are paid Reducing this gap would result in Medicaid rates that track more closely to actual cost experience, and would mean that fewer homes would experience the kind of significant difference between actual costs and rates that can necessitate EFR.

Options for changes include, but are not limited to, aligning the rebasing frequency of the Resident Care, Director of Nursing, and Indirect cost components with a two-year cycle (instead of the current four-year cycle), and adopting an annual (instead of every other year) rebasing schedule for the Nursing cost component. Because Nursing costs are most sensitive to wage inflation, agency utilization, and staffing shortages, annual rebasing would enable rates to reflect real-time labor market conditions. High nursing labor costs represent the largest single driver of EFR need in recent years.

Other Measures to Strengthen Nursing Home Financial Stability

A. Review of Step-Up Process for Ownership Transitions

Another possible option is to modify the 'change in basis for qualifying transfers' (Step-Up) process governing ownership and operational transitions. A Step-Up occurs when a nursing home is sold and Medicaid resets the facility's asset values, such as the building and equipment, to establish a new depreciation basis for the Property & Related rate. The current methodology inflates building values using the lower of the Consumer Price Index (CPI) or a construction cost index. In today's economy, the gap between these indices has grown significantly. CPI tracks general household goods and services, which historically underestimates the increase in the cost of construction. As a result, using CPI can produce excessively low Step-Up values when nursing homes are sold, failing to reflect the real investment required to replace or improve a facility.

A change to the methodology could address this disparity while maintaining reasonable limits: the allowed Step-Up value could use only a construction cost index when it more accurately reflects building value. Additional provisions, such as the previous owner holding the property for 12 years, may also need updating to reflect current market

conditions. Such changes could better align Step-Up valuations with current costs, and could potentially encourage continued local ownership of Vermont nursing homes.

B. Improve Case-mix Accuracy through Validation Audits and Education

The Division has engaged an independent contractor to conduct a data validation audit and education initiative aimed at improving the accuracy and consistency of Patient-Driven Payment Model (PDPM) data across Vermont nursing homes. These validation audits will review facility documentation, coding practices, and Case Mix Index (CMI) calculations. Following the audits, a structured education and technical assistance phase, led by the contractor, will provide training on necessary documentation and coding to support more accurate case mix scores. By improving PDPM reporting accuracy and provider understanding, this initiative is expected to enhance consistency and fairness in reimbursement and potentially help reduce the frequency of facilities requiring EFR support.

The number of facilities experiencing significant decreases in the Nursing Care component of the rate (defined as a reduction greater than $5 per day) has increased over time. In SFY 2024, under the longstanding Resource Utilization Group IV (RUG-IV) system, which relied on facilities self-reporting their scores directly to the State, two facilities experienced such decreases. This method depended on each facility's documentation and submission accuracy. SFY 2025 marked Vermont's transition from RUG-IV to PDPM, with mixed reporting throughout the year: Q1 was 25% PDPM / 75% RUG-IV, Q2 50% PDPM / 50% RUG-IV, Q3 75% PDPM / 25% RUG-IV, and Q4 100% PDPM. During this transition, five facilities experienced significant Nursing Care decreases. The SFY 2026 nursing rebase, which used 100% PDPM with scores calculated directly from CMS data rather than relying on facility self-reporting, resulted in ten facilities experiencing decreases, highlighting both the impact of the system transition and the importance of accurate PDPM documentation and education.

C. Training on Special Rates and Mid-Year Rate Adjustments

Beyond direct rate changes, the Division is planning expanded provider trainings on special rate requests and mid-year rate adjustment procedures. These sessions will clarify eligibility criteria, documentation standards, and submission timelines to ensure that facilities can pursue timely, appropriate rate adjustments. Many providers are not fully familiar with the special rates process and available rate adjustments for renovations or large asset purchases. Expanding training will help improve understanding of these opportunities to improve financial positions and ensure that facilities can navigate these procedures effectively.

NEXT STEPS

DVHA and DAIL will implement the following beginning in 2026:

- launching PDPM validation audits with an associated provider education period; and
- implementing provider trainings on special rate requests and mid-year rate adjustment procedures.

The remaining potential changes discussed in this report have the opportunity to improve nursing homes' financial positions, but additional stakeholder engagement will be essential in order to determine how to prioritize such changes and to fully understand the potential fiscal implications. DVHA and DAIL propose to engage in more substantive discussions with key partners around each of the following policy options as part of the Agency's broader, ongoing work to plan for the sustainability of Vermont's long-term care system, which also includes efforts to address workforce constraints and efforts to build additional system capacity to serve more Vermonters and address more complex future needs:

- aligning rebasing of Resident Care, Director of Nursing, and Indirect components on a two-year cycle and/or rebasing Nursing Care costs annually;
- establishing higher per diem limits on costs for specific peer groups of nursing homes (e.g., facilities with 40 or fewer beds); and
- reviewing the Step-Up process to eliminate or adjust the current 12-year ownership requirement, allowing greater coverage of interest and depreciation costs that are severely limited under the current Step-Up rules, and replacing the lower-of the CPI or the Construction Index provision with sole use of the Construction Index, a measure that better reflects building values during ownership transitions.

If implemented, these measures would not eliminate all financial pressures that Vermont nursing homes experience. Workforce shortages, agency staffing costs, and demographic changes will continue to challenge providers, but these potential adjustments could directly address the limitations in Vermont Medicaid rate setting that contribute to recurring EFR requests. EFR would remain available as a safety net, but these potential policy changes could make its use less frequent, less urgent, and more predictable.

APPENDIX 1 — DATA AND FINANCIAL TABLES

Purpose: This appendix provides the underlying data for the charts and analyses in the main report and shows the numeric basis for EFR trends and cost cap analyses.

Charts

Chart 1: EFR Requests by Fiscal Year

Total EFR requests submitted and granted from SFY 2022 through SFY 2026.

Fiscal Year	Requests Granted	Requests Denied	Requests Incomplete	Requests Pending Review	Requests Withdrawn
SFY 2022	5				
SFY 2023	11		1		
SFY 2024	8	3	1		8
SFY 2025	6		3		
SFY 2026*	1	1		3	

*Partial year data as of December 1, 2025.

Chart 2: Distribution of Vermont Nursing Homes by Facility Size

Shows the number of nursing homes in Vermont by licensed bed count. About one-third of facilities fall in the 30–40 and 41–60 bed ranges. This distribution is relevant for understanding cost cap impacts, as smaller homes face higher per-resident costs and hospital-related or larger homes face elevated operating costs.

Facility Size (Beds)	Number of Facilities
30-40	4
41-60	7
61-80	5
81-100	7
101-120	2
121-140	4
141-160	4
Grand Total	**33**

Chart 3: EFR Granted by Facility Size (SFY 2022–SFY 2026)

Total EFR funding granted, broken down by facility size.

Facility Size (Beds)	Total EFR Granted
30-40	9,775,961.00
41-60	12,496,813.67
61-80	5,773,133.00
81-100	5,046,525.00
101-120	1,459,247.00
121-140	2,438,580.00
141-160	3,509,680.00

Table 1: Percentage of Facilities Exceeding Resident Care Cost Caps, by Size and Ownership Type

Shows the share of facilities reaching cost caps in the Resident Care category, highlighting the overrepresentation of smaller homes.

Facility Size	Total Number of Facilities	Number of For-Profit Facilities	Number of For-Profit Facilities Capped	For-Profit (%)	Number of Non-Profit Facilities	Number of Non-Profit Facilities Capped	Non-Profit (%)	Number of Hospital-Related Facilities	Number of Hospital-Related Facilities Capped	Hospital-Related (%)
30-40	4	2	1	50%	1	1	100%	1	1	100%
41-60	7	3	-	0%	4	1	25%	-	-	0%
61-80	5	4	1	25%	1	-	0%	-	-	0%
81-100	7	6	-	0%	-	-	0%	1	1	100%
101-120	2	2	-	0%	-	-	0%	-	-	0%
121-140	4	3	-	0%	-	-	0%	-	-	0%
141-160	4	3	-	0%	-	-	0%	1	-	0%

Table 2: Percentage of Facilities Exceeding Indirect Cost Caps, by Size and Ownership Type

Shows the share of facilities reaching cost caps in the Indirect category, including hospital-related facilities and smaller homes.

Facility Size	Total Number of Facilities	Number of For-Profit Facilities	Number of For-Profit Facilities Capped	For-Profit (%)	Number of Non-Profit Facilities	Number of Non-Profit Facilities Capped	Non-Profit (%)	Number of Hospital-Related Facilities	Number of Hospital-Related Facilities Capped	Hospital-Related (%)
30-40	4	2	1	50%	1	1	100%	1	1	100%
41-60	7	3	1	33%	4	3	75%	-	-	0%
61-80	5	4	1	25%	1	-	0%	-	-	0%
81-100	7	6	-	0%	-	-	0%	1	1	100%
101-120	2	2	-	0%	-	-	0%	-	-	0%
121-140	4	3	-	0%	-	-	0%	-	-	0%
141-160	4	3	-	0%	-	-	0%	1	1	100%