January 14, 2016

Testimony to the Joint House Health Care / Human Services Committee
Judy Peterson, CEO VNA of Chittenden and Grand Isle Counties

January 7, 2016

Testimony to the Senate Committee on Health and Welfare
Peter Cobb, Director

Accountable Care Organizations (ACOs) and Home Health

Thank you for the opportunity to comment on ACOs and home health.

VNAVT members have been working hard to be actively engaged in the health reform discussions since the beginning over three years ago. We have followed the debate from the Single-payer proposals to the current discussions on the all-payer model and Accountable Care Organizations. We are confident that our voice has been heard and that all parties involved – State, ACOs, advocates and other community providers - recognize not only the value of home health service but also the fact that health reform cannot succeed without a strong home health system.

Home care is the key provider for home health and hospice services, including case management, for our patients. We have a proven record of success.

Background

- All VNAs of Vermont members are affiliated with both OneCare and Community Health Accountable Care (CHAC).
- VNAVT has a representative on the boards of directors for both OneCare and CHAC.
- VNAVT has representatives on the clinical advisory committees of both OneCare and CHAC.
- VNAVT members are active participants on OneCare's regional clinical focus groups.

Concerns

- The process to an all-payer waiver is moving very fast. Will home care be included and if so how?

- The State appears to favor the ACO model (possible just one ACO statewide) as the preferred provider for all services. What does this mean for home care and other community-based providers?
- Most of the health reform discussions have been hospital-based and not community- and prevention-focused.
- No one is really discussing the costs of a new infrastructure.
- Medicaid payments are too low. What will the new payment system do to improve Medicaid payments to home care agencies?
- How will the ACOs assure that there is no duplication of effort concerning case management and other community-based services?

Recommendations:

1. **Hospice** - Focus on expanding hospice services. There are many people who could benefit from hospice and palliative care services even while they are receiving curative care, and for some of them this approach would result in earlier admission to hospice services and reduced hospital use and expensive yet sometimes futile treatment of their disease. Payment for this service would save the system as some hospital stays would be reduced or eliminated.

2. **Chronic Care Management/Preventive Nursing** (Longitudinal Care) - Fund nursing services in between Medicare episodes of care to provide care to chronic care patients with high needs - “Longitudinal Care”. Many people who no longer meet the definition of acute or “homebound” are at risk for rehospitlization once home care services are terminated. They would benefit greatly from regular check-in visits/phone calls from a nurse, access to 24/7 on-call nurse, and, if needed, telemonitoring services. This could be as seldom as once or twice a month. Pilots in other parts of the country have demonstrated that this ongoing care coordination can prevent re-hospitalization and ED utilization. A modest investment could provide one FTE nurse in each VNA to provide this service to dozens of people who otherwise may have another acute episode and be rehospitalized.

3. **Choices for Care** - Restructure the Choices for Care Program. Most VNA’s lose money on this very worthy and successful program, which saves the state significant money as it prevents or delays nursing home admissions. This is because the rates for service have not been increased significantly in years. If providers are losing significant money on every admission to the program, there is no incentive to grow the program. The program funding should be re-structured into case mix or bundled payment. In addition, the providers should be guaranteed 50% of any savings. This would create the right incentive to grow the program, thus provide more savings to the state, and also address the providers’ losses.

4. **At-Risk Families** - Increase access to nurse home visiting for at-risk families. Most VNA’s in Vermont currently provide services through the Nurse Family Partnership program to first time, at-risk mothers. This service should be available to all at-risk mothers. This should be done in conjunction with the state’s Integrated Family

Services initiative. Providing services that build strong families has been shown to prevent unhealthy lifestyles, chronic disease and even incarceration later in life. This is true “population health”.

5. **Rules** - There are several unnecessary home rules such as the “homebound” rule (patient must be confined to his home to qualify for Medicare) and the face-to-face requirement (required form to certify physician’s orders – currently the rule is cumbersome and confusing) that could be eliminated because they do not add value but do add extra cost.

6. **Rehabilitation** - Increase opportunities for in-home rehabilitation, when appropriate (to replace more expensive rehabilitation in an instructional setting).

7. **Regional Payments** - All-payer payment should be made on a regional basis, with the providers in each region working together to determine how the money is spent. Each region is different and payments decisions should make locally.

Home Health and Home Health Reform

Most people want to stay in their homes, even as they age and become frail. Accountable Care Organizations want to provide better care at lower costs. Home Health and Hospice are ideal partners in achieving these goals. Without home health, it is unlikely that an ACO can meet the triple aim of health reform – better quality, higher patient satisfaction and lower costs.

Home Care’s Focus

- Keeping Vermonters healthy by teaching and reinforcing healthy lifestyles
- Helping those with complex chronic conditions manage their care
- Better managing end-of-life care
- Giving kids in at-risk families a healthy start
- Investing in lower cost interventions
- Integrating primary care with mental health, home health and other community social services

Role of Home Health in Meeting ACO Goals

Improving care and reducing costs

Reducing hospitalizations and rehospitalizations

- Managing care transitions
- Chronic care management
- Minimizing risk of falls

Reducing ED utilization

- Education and awareness of home health services
- Case management for frequent users (and those meeting certain profile i.e. 85+ and lives alone?)

- Express referral process

Supporting patients and families in end-of-life care decision making

- Enhanced Palliative care benefit (also called Supportive Care)
- Counseling for patients and families on end-of-life care options (Palliative care nurse as part of Community Health Team?)
- Pain and symptom management expertise
- Social and emotional support

Home health is organized around a case management model

- Nurse case management assessment, planning, coordinating and evaluation of care
- Specialists to support care plan – PT, OT, SLP, Psych, MSW, LNA, Dieticians, Palliative Care and Hospice Nurses
- Interdisciplinary Care Conferences

Staff knowledgeable about and have relationships with community partners

- Works with all primary care and many specialty practices
- Aware of social, housing and financial supports and can connect patients with them

Infrastructure in place to support the process

Proven Results

Home care has a proven record of success providing a wide variety of in-home services to chronic care patients. One example of many is the Choices for Care program. CFC gives elderly, frail Vermonters, who are eligible for nursing home care, the option to receive services at home rather than in the nursing home. Home care agencies provide case management, respite care, personal care attendants and homemaker services for this program. The patient satisfaction results for this program consistently have been among the highest for all state programs.

Cost Effective

According to a financial report produced by the Department of Disabilities Aging and Independent Living, in SFY2015 the average annualized cost for nursing home care was $68,620 compared to an average cost of $29,040 for home and community based services (including residential care and assisted living). While people living in the community often use other services and supports that reduce the difference in costs, home and community based services represent a cost effective alternative for those people who can manage at home.

Cost savings from home health services are not limited to chronic patients. According to the data from the Centers for Medicare and Medicaid Services (CMS), the average cost to serve patients at home with major joint replacements (MS-DRG 470), from 2007-2009 was $18,068 compared to $26,861 in nursing homes, $30,302 in hospitals and $57,896 at rehab facilities and the outcomes from home care are as good or better.

Questions? Call 229-0579