Vermont Care Partners Response to
Questions from Senate Health and Welfare on All Payer Model
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1. If there is no All Payer Model what is the alternative?

Just two short years ago and we had the rise of the Accountable Care Organizations. We have come a long way from that point. At the time, we were all trying to figure out what it would mean for the system, but conceptually, we knew it would lead us to more integrated systems. We were wary of a medical model. As DA/SSAs, we accentuated the influence of social determinants of health because we know how they impact health. We worked on individual and statewide outcome measures, and began to participate in regional provider network initiatives.

As a state, we then moved toward the APM, which was originally envisioned to include all health care and community providers. We believe the APM holds great promise if fully implemented to include all service providers within the health care arena. We also recognize that the APM will use the ACO as its vehicle and, depending upon how that is constructed in the final analysis, we voice our support.

If there were to be no APM, OneCare Vermont would proceed to participate in the Medicare Next Generation Wavier. This waiver does not have the same level of flexibility and does not have a floor for health care expenditure growth. Designated and Specialized Service Agencies (DA/SSAs) could continue to work with the Agency of Human Services on payment reform, developing value based payment methodologies for our Medicaid funded services which account for 85% of our funding and could be participating providers with the ACOs. The Medicaid 1115 waiver gives enough flexibility to continue to design payment reform.

2. Do you have suggestions for term sheet changes?

We are very appreciative that we, as community services, are included under the Commitment to Create an Integrated Health System. The words are: "The State will continue to work with existing mental health, substance abuse, and long term services and support providers to determine the best path forward to create an integrated health care system. "

We would prefer to be included in the term sheet section: Seeking Additional Investments in Vermont's Health Infrastructure. This section highlights, "SASH, Hub and Spoke, and Blueprint," It should include DA/SSAs, Area Agencies on Aging and Home Health Agencies because we all have proven track records of saving money while supporting people to live in their communities and preventing hospitalizations on a daily basis. While we doubt we would be added in immediately, we are hopeful that the voiced commitment will be realized. We, the DA/SSA system, are in a very precarious financial state, supporting an extremely vulnerable population. Best intentions , e.g., working with community providers to determine the best path forward," permit a level of uncertainty in setting a specific goal and that raises the question of developing legislative language to assure inclusion.

We understand that the Vermont Care Organization (the combination of the three existing ACOs) would work toward inclusion of our service delivery system and we welcome that inclusion but we are not certain, at this point, how and if it will happen. If the designated agency system is included in the APM spending caps, then we would recommend that the caps be raised.

3. What are your biggest fears, specific concerns, and anticipated effects?

- Public resources for disability, long term services and support (DLTSS) could be primarily allocated based on the impact on health care expenditures. This could result in some critical human services losing visibility and resources over time if they are not recognized as impacting health care spending.
- Decision making on DLTSS appropriations, policy and services could move away from the public sector and into a private corporation with less public input, feedback and involvement.
- The focus on reducing health care expenditures is likely to lead to the closure of community health and human service organizations ranging from small hospitals to designated and specialized service agencies. This could lead to: reduced access to health care, services and supports; less responsiveness to specific local needs; fewer home and community based non-medical services; less oversight by local consumers, family members and community leaders; less opportunity to focus programming on individualized needs.
- If local agencies are eliminated it will have significant economic impact on local communities where these agencies both provide employment and enable people with disabilities and mental health conditions achieve employment.
- Most of the quality measures are likely to have a medical focus and could lead to focusing resources on medical care and away from best practices for home and community based services.
- As long as many Vermonters served by community providers are not attributed to the ACO(s) DLTSS providers may have fragmented funding streams, oversight, reporting, outcome measures, etc. from the ACO(s) and state government.
- While community service organizations struggle, hospitals that have healthy revenues may decide to build some elements of service provision currently provided by DAs and SSAs, thus setting a new floor for salaries and hiring away community based staff.

4. What would you like the legislature to act on?

- Clarifying principles for the APM implementation and agreements between the State and the ACO(s) to ensure inclusion and support for community providers in developing an integrated health system.
- Support of the role of regions to collaboratively design, develop and manage local health care, DLTSS and integration and quality improvement efforts.
- Ensuring that funding levels for DLTSS services are adequate to meet needs and are not capped at levels that prevent parity in access to these services.
- Ensure that Medicaid reimbursement rates will be adequate enough to address workforce challenges to ensure access to quality services. This may require a significant one-time boost in rates and improve payment models to allow providers to compete for qualified staff and ensure equitable access to services and supports.
- Ensuring that consumer protection process will be effective.

5. Please provide specific suggestions for language/principles to ensure patients' rights, transparency and accountability?

1. Reform of health care should address the social determinants of health.

2. Funding for health reform efforts needs to include investments in DLTSS such as home health, mental health, developmental disabilities, substance abuse and social services that contribute to avoiding or reducing the utilization of higher cost services.
3. Primary care must be strengthened, including strategies for recruiting more primary care physicians and providing resources to expand capacity in exiting practices.
4. Planning for reform efforts must be based on local or regional planning conducted by the various community health providers, with evaluation of best practice for replication and return on investment.
5. The ACO(s) should responsibly re-direct funding from high cost services to efficient and effective community support, prevention and health improvement services.

The VCO shall:

1. Utilize a governance model that is inclusive and balanced so that no one provider or provider group can control decision-making. "Inclusive" means having participation from at least VNA's, DA/SSA, AAA's and consumers of services.
2. Contract with existing providers for community support services, to include mental health, developmental disability services, substance abuse services, home health, care management, therapy and outreach and adult day programs.

How do you expect your inclusion in ACOs and the All Payer Model to affect patients and providers?

1. There is a tremendous opportunity to improve the integration of health and human services at the state and local levels through:
    a. Learning Collaboratives
    b. Health Service Area Initiatives
    c. Integrated Family Services
    d. Peer Learning Lab
    e. Care Coordination Core Competencies
2. Health care resources can be redirected to the social determinants of health to achieve improved population health and reduce expenditures for high cost medical care.
3. Quality improvement can be conducted with a systematic approach using advanced informatics to measures and improve quality outcomes and cost-effectiveness across health and human services.
4. We will be better able to address co-morbid conditions with developmental, mental health and substance use disorder components.
5. Care coordination strategies across providers will be improved and create more cost-effective and efficacious care
6. Support for regions to create this integrated approach, with appropriate infrastructure, will make it easier for patients to navigate the system and feel more supported.
7. Peer voice in this process is extremely important. In the designated agency system, we have encouraged and respected this voice for years. More than 50% of our Boards members are family members and consumers It is essential that we move toward developing a strong peer voice in our regions.
8. DA/SSAs could contribute to improved quality of care by educating other health providers about person-centered, individualized approaches to health care and support services.
9. In conclusion, we support the APM due to its flexibility, intent to build a broad health care system.