TO: All Gobeille, Chairman
Green Mountain Care Board Members: Cornelius Hogan, Betty Rambur, Allan Ramsay, Jessica Holmes
Richard Slusky, Susan Barrett, Ena Backus, Agency Directors
FROM: Peter Cobb, VNAs of Vermont
RE: All-Payer Model - Term Sheet
DATE: February 16, 2016

Please consider the following comments from the VNAs of Vermont concerning the all-payer model and the term sheet agreement. In addition, a series of questions is provided at the end of this document. VNAVT represents the 10 Visiting Nurse Associations and non-profit hospice organizations.

The VNAVT members are cautiously optimistic that the move to an all-payer system makes sense and that better coordination among all providers - hospitals, home health, physicians, mental health and other community providers - will help the State meet the triple aim of health reform - better quality, higher patient satisfaction and lower costs. These goals cannot be met, however, unless home health and other community-based providers are equal partners with institution-based health systems.

Home health agencies in Vermont are crucially important to real and effective health care reform. To be successful we need to pay attention to all aspects of health improvement, not just access to care and hospital costs. Home health agencies in Vermont stand ready to lead the community-based effort to improve the health of the whole community, from new families to frail elders and every one in between.

Term #3 Provision to ensure all existing protections for Medicare beneficiaries - This term is essential for both consumers and community-based providers.

Term # 4 Basic Payment Waivers - VNAVT supports ending fee-for-service for most health care transactions. Home care is set to switch to prospective payments on July 1, 2016. Our concern is with payments. The State must fund PPS for home care adequately otherwise several agencies could be placed in serious financial jeopardy. Level funding for FY 2017 will not get the job done.

Term # 5 Medicare Innovation Waivers

- *Authorize telehealth services for all beneficiaries*. It is our understanding that telehealth in the waiver term sheet refers to video conferencing by physicians and patients.

VNAVT supports expansion of this service. GMCB should also consider expanding telemonoriting by Medicare-certified home care agencies. Telemonitoring is the monitoring of vital signs and other important factors crucial for the patient's wellbeing. Currently, Medicaid limits home care telemonitoring to CHF patients only. This is too limiting and should be expanded to include all patients for whom telemonitoring would provide a clinical benefit. Telemonitoring should be limited, however, to Medicare-certified agencies, the agencies already providing this service and not be an unlimited benefit.

- *Enable home visits without physician supervision*. VNAVT supports this waiver. Currently, to qualify for home health services for both Medicare and Medicaid, a patient must need skilled services on a regular and "intermittent" basis. Once the patient is stabilized, the agency must discharge him/her from service. The next time the agency can see the patient is after his next hospitalization. Often, patients with multiple chronic diseases and without ongoing care management, intermittent assessments and access to the 24 hour on-call nurse support offered by home health, continue to bounce back and forth between home care and the hospital. Ongoing support "longitudinal care" for patients with complex chronic needs would greatly decrease the total cost of care by reducing both emergency room visits and the use of acute care facility services.

  VNAVT strongly opposes the section of this term that would allow "ACOs to contract for home visits with other licensed clinicians." There is no need, whatsoever, to open home health care to non-certified agencies. That would be expensive, wasteful and duplicative. Home care agencies have the infrastructure already in place. We are the experts in community-based health care.

- *Expand Nurse Practitioners scope of practice.* Vermont should eliminate the rule that prohibits Nurse Practitioners (NP) and Physician Assistants (PA) from certifying that a patient is eligible for home care services. NPs and PAs are playing an increasingly important role in the delivery of health care, particularly in rural and underserved areas. They are a cost effective alternative and provide needed services, especially in areas with physician shortages, which includes most of Vermont. Current rules allow NPs and PAs to provide some physician services and they can certify Medicare eligibility to a skilled nursing facility but they cannot qualify a patient for effective, less costly home care nor can they alter the home care plan of care. Adding them to the list of those who can qualify a patient for home services and develop a plan of care would be consistent with the triple aim of health reform.

- *Enhance the availability of home care and hospice services*. We strongly support eliminating some of the eligibility rules that impede home care and hospice eligibility such as the Medicare's homebound requirement, the face-to-care physician eligibility requirement and the six month prognosis of death to qualify for hospice.

Term # 6 Infrastructure Payment Waivers - This term would provide for continued funding for Vermont's Blueprint for Health and for the expansion of the SASH program. We support the Blueprint and support expansion of the SASH concept - community-based prevention producing

better results. There is some confusion, however, about what SASH is and what it is not. The SASH concept includes all the current providers – home health, mental health, SASH staff, adult day services and Area Agency on Aging. The SASH organization provides services to patients in congregate housing settings. SASH does not now, nor should it provide services already provided by home health or other community providers. If there is SASH services expansion into the community, SASH should pay the community providers (home health, AAAs, mental health) that already provide these services. Adding SASH staff to home-based care would be duplicative and costly.

Term #10 Rate Setting - *Vermont will maintain all payer rate setting system for all regulated services.* Currently, there is no rate setting for home health. Over the past decade Medicaid rate increases to home care agencies have not matched the consumer price index inflation rate, not even close, and the gap between payments and costs has widened. This waiver might improve that situation.

Term # 11 ACO - *"Vermont will utilize an ACO model under the all-payer model."* State planners must assure that community providers are equal players and that the needs of the consumers are met. This will not work with top-down decision making where all major decisions, financial and programmatic, are made by the hospital representatives of the ACO.

Term # 12 Regulated Services - Under this term, the Green Mountain Care Board will "regulate" all Medicare Part A and B services. Home care is a Medicare A provider. What changes, if any, would this term mean to home care agencies? Home care is highly regulated now. Additional regulatory burdens would be costly and unnecessary.

Term # 13 Cost Containment - This term of the agreement limits spending. We have no problem with that so long as this is not an across-the-board limit and that the GMCB board recognizes that increased spending in certain areas, such as home health, could produce significant savings by reducing spending in more expensive settings.

Population Health - The key to keeping costs down is aggressive case/care management at the community level with a focus on "population health" (moving the health care system toward management and prevention of disease rather than "illness care"). VNAVT supports the new emphasis on population health.

Primary Care - We agree that boosting primary care in Vermont is important.

Questions from Home Health

Computer Model - The Green Mountain Care Board is using a computer model to determine the costs for all-payer. It is not clear what factors are included in this model. Are cause and effect data included such as if a hospice death is less expensive than a death in a hospital; increases in hospice would decrease hospital costs? If the model only includes spending by site and provider and does not include adjustments for increases to services that will decrease overall costs, it will not work.

All-payer - Will home care be included in the all-payer payments and if so when would all-payer payments begin?

Medicaid Tax - How will this work if home care is included in the all-payer waiver?

Payments - How will all-payer assure that home care payments match costs?

ACO Payments - If all funds are paid to the ACO, how will home care be paid?

Community-based Services - What incentives will the ACO have to contract with home health and other community providers? Home care opposes having the ACO establish its own home care system.

Governance - How will GMCB assure that home health and hospice is an equal party to the ACO and all-payer decision making?

Home Care Only Patients - If homecare is in the all-payer system that is managed by the ACO, how will the agencies be paid for services for patients who get only home care?

Cost to Run the ACO - How will the cost to run the ACO be paid? Will home care and other providers be assessed ACO dues?

Cost to Monitor the ACO - Will the State/GMCB keep a portion of Medicare/Medicaid funds to pay for its increased oversight and regulation?

Increases to Home Health - Unless home health services are increased, it is unlikely that the ACO can meet the triple aim of health reform. Is there a commitment to increase funding to home health and hospice?