DISABILITY RIGHTS VERMONT

Formerly Vermont Protection & Advocacy
(800) 834-7890 (Toll Free)
(802) 229-1355 (Voice)
(802) 229-1359 (Fax)

141 Main Street, Suite # 7, Montpelier, VT 05602

Date: December 13, 2018
To: The Green Mountain Care Board (GMCB)
From: Ed Paquin, Executive Director, DRVT
In Re.: GMCB review of One Care Vermont (OCV) proposed 2019 Budget

Dear Chair Mullin and Members of the Green Mountain Care Board,

Disability Rights Vermont appreciates the opportunity to comment on the One Care Vermont (OCV) proposed 2019 budget. DRVT is the designated protection & advocacy agency for Vermont and as such we are federally funded to investigate abuse, neglect and rights violations against people with disabilities and are supported to advocate for their needs and rights at all levels of the service delivery system. We are also the state's Mental Health Care Ombudsman. We are not actuaries, health care providers, nor hospital administrators but have considerable experience in representing the needs of people with disabilities as they endeavor to get the medical and long term care they need to live useful, independent lives in their communities. Although we are a largely publicly-funded not-for-profit, we are indeed a small business and contend with health insurance costs that generally inflate between 3 and 6 times the annual CPI inflation rate.

DRVT believes that the One Care Vermont budget needs to be evaluated and understood in the broadest context

of health care reform, and the GMCB should be mindful of possible effects on long term services beyond acute care. The distinguishing feature of the current health care reform is that it is "provider led." As the organizer of providers, OCV represents a centralizing of control in health care. The UVM Medical Center, a central influence in OCV, represents a consolidation of control in health care. There are a variety of successful consolidated acute health care delivery systems throughout the industrialized countries, but in all of them, whether single or multiple payer, the public has a controlling influence, whether through strong public regulation of a privately run system as in Canada and much of Europe or through direct control as in Great Britain. The GMCB is the only entity in a position to meaningfully regulate the development of OCV as the central power in Vermont's All Payer health care reform.

As payment reform moves towards capitation, we need to be aware that this is not the first time that the mechanism of capitation has been tried, and not always with desirable results. The difference this time is the assumption that health outcomes will insure that cost control will not be at the expense of quality. The results we have seen to date in cost control are not impressive, and the specific measures of outcomes seem questionable in their utility and scope. DRVT does not see the current outcomes as comprehensive measures of population health and the fact that "points" have been scored, with financial reward, even on measures without national standards or year-to-year improvement does not give confidence that they insure quality. This has been our observation since outcomes were first debated in the SIM grant process, when any attempt to broaden measures was hotly opposed by providers. If ACO reimbursement is to be accountable based on outcomes, there need to be real, transparent and broad measures. GMCB members need to ask whether they are satisfied that current measures really show progress toward a more effective system and a healthier population.

People with disabilities rely on the publically funded long-term care system when they don't have the personal wealth to provide for care that may be both intensive and lifelong. You are being asked to approve a budget that mobilizes public dollars to build an infrastructure in the acute care system, and that requires alignment with long term care. As the largely institutionally-based acute care system shifts costs to Vermont's privately insured population, inflation in the

Medicaid funded long-term care system is more tightly controlled by the Administration and Legislature. There is irony that there seems to be a willingness to use public monies to control costs by creating an infrastructure consisting of parties heretofore incapable of controlling costs, while requiring "budget neutrality" in the payment reform process currently underway with the developmental and mental health services systems.

A strong community-based system of mental health and developmental services succeeded over time in moving thousands of people out of institutions such as the Vermont State Hospital and the Brandon Training School. But in the past two decades, tough budgeting has weakened that public infrastructure to the point that we find ourselves with an over-stressed system, particularly with regards to mental health services. Again, it is ironic, though not surprising, that the solution offered by the UVMMC is to increase their inpatient capacity by developing new institutional services.

DRVT does not have ideological opposition to the All-Payer model, or to capitated payment reform, or even to the concept of Accountable Care Organizations. We do not, however, see that the development of the current single PLAYER, One Care Vermont, has had regulation robust enough to ensure that more people get access to better, more affordable care. In this we agree with several who have already submitted comments and in particular hope that the GMCB pays close attention to the detailed comments of the Vermont Health Care Advocate.

Our concerns are not new. We are attaching comments that were put together for the SIM project by the Vermont Coalition for Disability Rights in 2013. Many things have changed since then, but the fundamental differences in the economic forces on the acute care and long term care systems have not.

Thank you for your attention to our comments and thank you for your work to improve access to affordable, quality health care in Vermont.

Respectfully,

Ed Paquin, Executive Director, DRVT

VCDR
VERMONT COALITION FOR DISABILITY RIGHTS
Nothing About Us Without Us

11 EAST STATE STREET, SUITE #2
MONTPELIER, VT 05602
TEL: 1 (800) 639-1522
WWW.VCDR.ORG

SIM/Duals Steering Committee Members,

I am unable to attend our meeting on Thursday, so I am submitting written comments on behalf of the Vermont Coalition for Disability Rights.

The state and many private partners are contemplating major changes in the way that health care is delivered and paid for in Vermont. It is currently envisioned that the ACO model could reward “organizations” willing to deliver comprehensive care and reduce the rate of increase in the cost of care. The ACO approach divides populations served by payer and soon to be considered is an RFP for Medicaid ACOs. It is crucial at this point to acknowledge that the envisioned ACO structure and some of the entities that may end up with control are institutions very much in the "medical model" and NOT the most qualified for delivering long term care.

Vermont's biggest successes have been when we have tailored long term care to meet individuals' needs - and on their terms. Among those reliant on Medicaid we have the least institutional mental health care system in the country, we have one six bed ICF-DD and no other state "institutions" for people with developmental disabilities, and older Vermonters have the right to choose between receiving care in their homes and nursing facilities.

Our state’s long term care services have been thoughtfully developed over time and, insofar as the major payer is Medicaid, their costs are under tough annual review by both

the administration and the legislature. They are among the country's most cost effective. They are administered mostly by the private non-profit sector and fairly strongly regulated by the state. Much of what they deliver is offered in the social service model, and appropriately so. They make living in an integrated society at least POSSIBLE for elders and people with serious disabilities.

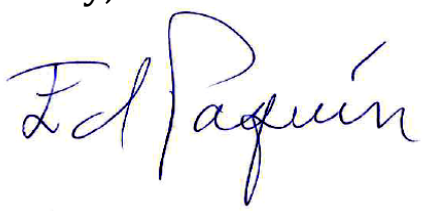
If your only tool is a hammer, everything looks like a nail. If hospital-based ACOs become the state's central mechanisms for cost containment in Medicare, and especially Medicaid, it doesn't take a lot of imagination to see an erosion of support for our long term care services. Even if institutions were to accept that their share of the state's economic "pie" is to decrease, their first priority is unlikely to be excellence in long-term care, an area quite outside their experience of acute care delivery.

We all need to be concerned about the strength and vitality of our acute care system in the new world of health care reform; we all rely on it and are grateful for it when we get all sorts preventive, emergency, crisis, and acute care. But we need to be aware that long term needs are often very different and require a different sort of infrastructure to be successful. Reforms in the business model of acute care delivery shouldn't mean sacrifice of what we have achieved for elders and people with disabilities.

Cost control of the acute care system has been elusive for years, but in long-term care we have legislative control over Medicaid budgets and hence direct control over inflation in the system. Every year we advocate to keep an adequate level of funding for numbers of elders and people with disabilities that increase as we all age and as prevalence of disability goes up. This is a GOOD thing, it means that both our acute and long-

term care systems are helping people to live longer and better. Similar control is less clear in acute care because of the system's ability to cost shift when there is a need to make up for tight control of Medicaid/Medicare, for uncompensated care, or changes in technology. Any of us in the private market RARELY see insurance rates only go up by single digits! Elders and people with disabilities need to have a more central place in reform of the system if key decisions about long term care delivery are to be folded into corporate structures with no real experience in their delivery. A new payment structure for long term care that is tied in with hospital reimbursement can easily be envisioned. However a new system is structured it should have enforceable and clearly defined safeguards and standards to preserve Vermont's long term care system. Those standards must be arrived at through real public input. People with disabilities and elders are the real experts in living with long term needs.

Sincerely,



Ed Paquin
President, Vermont Coalition for Disability Rights