bvna More than you'd expect from home care.
Brockton Visiting Nurse Association

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September 8, 2014

To: David Seltz
Executive Director
Health Planning Commission

The following information is a brief summary of the Brockton Visiting Nurse Association to accompany the formal testimony.

The Brockton Visiting Nurse Association, Inc.(BVNA) is over 100 years old. It was founded in 1904. It remains a not-for-profit certified home health care provider. The geographical service area covers 29 towns and cities in South Eastern, MA. The service area is a melting pot of races: made up of White, Black and Asian. Cape Verdean, Hispanic and Haitian are the largest cultural groups. Main languages spoken are English, Spanish, Portuguese Creole and French Creole. The population that is serviced by the Brockton Visiting Nurse Association (BVNA) ranges in age from birth to 100 years of age. The BVNA has 144 employees, made up of RNs (adult and pediatric), specialists in Diabetes, Complex Care, IVs, Respiratory, Cardiac, Oncology, Social Workers, PTs, OTs, Speech Language Pathologist, and Home Health Aides. All professional staff started using an Electronic Medical Record beginning in 2005.

Special Programs that the Brockton Visiting Nurse Association has are: ADA recognized Diabetes Program (one of the few in the Commonwealth at a VNA), Certified Wound Ostomy Continence Nurse who leads a WOCN program, Complex Care Program, Integrated Chronic Care Specialists, IV Program, Fall Prevention Program "It's a Joint Effort", Telehealth Program, Helpline Program, and Palliative Care Program.

Referral sources consist of Acute Care Hospitals, Local Hospitals, Boston Hospitals, Skilled Nursing facilities, Rehab facilities, Clinics, Neighborhood Health Center, Community agencies, Physician Offices and LTACs.

1. Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%

   Summary: Challenges abound in the current healthcare environment and within the certified Home Health Care industry. Certified home health care is of value in reducing rehospitalization and emergency room visits! Home Health Care is an important component of the health care continuum. Yet, we are faced with multi-year reductions in reimbursement with more regulatory compliance issues. Slim profit margins are eroding. The controlling of costs is critical. However, we have been reducing and controlling costs for years. How much more can we reduce?

   a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY2010-CY2013 and year-to date 2014? Please comment on the factors driving these trends.
      The first trend is reductions in payment for home health services from Medicare, Medicaid, or Commercial Payers. Commercial payers do not pay the full cost of certified home health care services. Medicare continues to decrease payments due to coding restrictions and other payment criteria. Each year CMS creates proposed rules followed by a comment period then the final rule is

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published in November, with implementation each January. The 2007 Medicaid rates were decreased by 2% in December of 2008 for patients who were on the home care caseload longer than 60 days. Not 60 visits. The second trend would be the decrease in Medicare referrals, and the increase in Medicaid referrals. For certified Home Health Care the preference is for Medicare referrals to help to defray the cost of caring for Medicaid patients. Appx 1.

b. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?
Resculpting of the Brockton Visiting Nurse Association (BVNA), utilizing the Triple AIM model to decrease costs, manage population health, and to provide excellent care with superior customer satisfaction. A Complex Care program was developed for the purpose of decreasing the ACH rate. Telehealth services focus on the Heart Failure patients, providing a higher level of care, and lowering ACH rates. Telehealth equipment is not funded! Working on the E-referral program at the Neighborhood Health Center to provide CDE services to diabetic patients in the community. Having a Palliative Care program that prepares patients for a transition to hospice care. Starting a Geriatric Behavioral Health program. Being re credentialed as an ADA recognized Diabetic program. During the 2012-2013 time frame the average cost per visit increased by 2.2%.

c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?
The Brockton Visiting Nurse Association is very "lean" and always has been. Certified Home Health Care is very different from other health care systems and organizations. Home Health Care is the least costly form of care. The Brockton VNA is developing a Lean Sigma model within the organization as a way to change culture and have an efficient work flow to decrease costs. BVNA will continue to control costs through: 1. analyzing metrics. 2. Educating the managerial employees to use benchmarking data to manage their employees work time to increase productivity. 3. Evaluate the efficiencies of the current EMR system. 4. Examine different payment methods and parallel cost effective ways of delivering care. 5. Enhance the benchmarking program. 6. Continue with physician partnerships and acute care partnerships.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
Having Commercial payers and Mass Health develop an episodic model for payments. The required authorization process is an administrative expense for home health care and the commercial payers. Eliminating the requirement of Medicare patients to be home bound would enable care to be provided in a much more creative way to keep patients from being readmitted to the acute care setting. There must be payment for telehealth. A very expensive investment that insurances do not cover. Payment for the American Diabetes Association recognized program by commercial payers. No insurance company pays for this special program in the home setting only in the hospital! Elimination of the federal face to face regulation. This is another huge administrative expense. Appx. 2.

2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.

Summary: The Brockton Visiting Nurse Association is very interested in APMs for the home health services provided and also for population health programs in the community for which there is currently

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no payment mechanism. The Brockton Visiting Nurse Association is competing with the 2 Pioneer ACOs for patients in our service area. It is truly a "dog eat dog" situation for patient referrals. Patients who are being transitioned to a skilled nursing facilty from a Pioneer ACO acute care facility are given forms to sign that the "patient" has made a choice and chosen the Pioneer ACO Home Health Care organization upon discharge from the skilled nursing facility. This is how they are given choice? SNF Administrators are being told if that does not happen then they will be penalized by not getting referrals in the future. BVNA has lost business due to this factor.

a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality performance, care delivery practices, referral patterns, and operations?
The Brockton Visiting Nurse Association is in discussion with an acute care facility re alternative payment methods. The BVNA would strongly encourage an APM model for Mass Health.
b. Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens).
We do not participate in an APM model therefore we do not have a formal analysis. The BVNA would be willing to provide an analysis on an APM model once the BVNA has been included in one.
c. Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population.
Refer to 2b.

3. Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers.

Summary: The Brockton VNA participates in no alternative payment contract models at this point in time.

a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?
The Brockton Visiting Nurse Association offers a Caring for Kids Program for children ages birth through 18 years. The purpose of the program is to keep these families together in their home environments and to provide these children the care and treatments they need at home rather than traveling back to the acute care setting. Payments from Mass Health and Commercial Insurers do not cover the cost of care because there is no risk adjustment. We are paid a flat fee-for-service rate. The Brockton Visiting Nurse Association is in discussion concerning a risk adjusted payment model.
b. How do the health status risk adjustment measures used by different payers compare?
Unable to answer.
c. How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?
Not applicable.

4. Another theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely,

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reliable, and actionable data and information to facilitate high-value care and performance under APMs. What types of data are or would be most valuable to your organization in this regard? In your response, please address (i) real time date to manage patient care and (ii) historic data or population-level data that would be helpful for population health management and/or financial modeling.

Summary: At this point in time, the Brockton Visiting Nurse Association participates in no alternative payment contract model. We are not aware of any other agencies who are participating in an APM. We are well positioned to be a critical partner in assisting physicians and others to achieve the aims of APMs across the care continuum by providing: primary care expansion for the home bound around prevention and wellness: post-acute care at various levels based on patient needs; and chronic illness management. Whether intentional or not, the unfortunate experience is that some APM models seem to support systems that are fully integrated or "closed", as opposed to models that support virtual integration through quality based contracting. These closed models threaten the existence of safety net hospital providers; they also threaten free standing community based home health providers. Appx. 3.

Answer: The Brockton Visiting Nurse Association has had an EMR since 2005. The expense for IT is very prohibitive. The BVNA is looking into an E-referral system and a physician portal. Real time data is so valuable for patient care. To be able to look at patient data from an acute care or skilled nursing facility and from medical appointments and for those facilities and offices to visualize BVNA patient data would greatly improve patient care. Right now it is very much a silo effect. Data is key to providing the highest level of care and reducing errors to patients. Thereby reducing the cost of healthcare. The BVNA Has begun to use an E-referral process with the Neighborhood Health Center. This is being piloted for diabetic patients who are in need of CDE services.

5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.

   Summary: Unable to answer.

   a. Which attribution methodologies most accurately account for patients you care for?
   b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?

6. Please discuss the level of effort required to report required quality measures to public and private payers, the extent to which quality measures vary across payers, and the resulting impact(s) on your organization.

   Summary: At the Brockton Visiting Nurse Association (BVNA) there is ongoing education to the professional providers about the OASIS Assessment tool. Consistency is so important so that the metrics that are produced are accurate. The education is costly. In addition, there are certified clinical coders in OASIS and coding who are members of our performance improvement team. The BVNA also has expenses for updating the OASIS Assessment tool on the EMR. This is charged to us by the software company. There is a process to load the data to the Massachusetts Department of Public Health. The CMS Home Health Compare reports are then available. This data report is not timely. To accurately see the patient improvement process the BVNA is making, additional software must be purchased. We have both Home Health gold and SHP. Appx. 4.

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Answer:

7. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers.

   Summary: The focus of this question is on the use of higher cost academic medical centers for inpatient acute care. The BVNA does not collect data on inpatient utilization trends.

   a. Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other higher cost care settings.
   b. Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the results of these efforts.
      The BVNA does track our own referrals and see a growing concentration in our market around care provided through agencies owned by or affiliated with Pioneer ACOs. Such a trend has limited options for vulnerable populations for accessing certain services. It makes it less possible for the BVNA to fairly compete according to typical market forces. As this concentration continues, there seems to be less and less market pressure to achieve efficiencies and pass those on to consumers via lower rates. Appx. 5.

8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially by hospital.

   Summary: Medicare bundling demonstrations are beginning to include certified home health agencies. BVNA would encourage the HPC to look at how these projects are managing, as data becomes available.

   a. Please describe ways that your organization is collaborating with primary care providers and hospitals to (i) optimize appropriate use of post-acute care after hospital discharge and (ii) identify the appropriate setting of care.
      The HPC's 2014 Cost Trends Report Supplement highlights that fact that "Massachusetts has a higher rate of discharge from hospitals to nursing facilities relative to the national average", suggesting an opportunity to manage post-acute care more efficiently. Brockton VNA could not agree more. The focus needs to be on the right care, at the right place, at the right time. BVNA has longstanding relationships with community hospitals and providers to see that patients receive care at home whenever it is appropriate and preferred. We have a program with an acute care facility to care for their complex patients in the patient's home and to prevent patients from being readmitted. In addition, we work with local MD practices and have weekly case conferences to keep this group of patients in their homes.
   b. Please describe your organization's efforts to manage the appropriate intensity and duration of post-acute care for your patients.
      The BVNA has metrics that enable us to monitor each provider of care to determine appropriate

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management of each patient that is on the caseload. Medicare has regulatory Conditions of Participation that must be followed. Policies are based on the COPs and managers must enforce those policies.

9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.

   Summary: As part of the admission packet, given to each patient, there is information provided re our Public Charges.

Health Care Service Price Inquiries				
Year		Number of Inquiries via Website	Number of Inquiries via Telephone/In Person	Average (approximate) Response Time to Inquiries*
CY2014	Q1			
	Q2			
	Q3			
	TOTAL:			

*Please indicate the unit of time reported.

Answer: No data has been requested.

10. Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.

    Summary: Patient referrals are negatively impacted by 1 or more limited network products. It is impossible to quantify referrals not received.

    Answer:

11. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.

    Summary: BVNA is just beginning a Geriatric Behavioral Health program. The visits are longer. The specialist is at a higher salary level. There have been and still are barriers related to Mass Health

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reimbursement. The state class rate for certified home health nursing does not recognize expenses associated with specialty services such as behavioral health or caring for fragile children as a result of their severe diagnoses. The Mass Health rates have not been adjusted, except downward in seven years! The HPC Report Supplement's section on behavioral health references previous findings stating that "among the five percent of patients with the highest levels of health care expenditures, total health care spending for people with at least one chronic medical condition and at least one behavioral health condition was 2.0-2.5 times higher than for people. Appx. 6.

a. Please describe ways that your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.
   Brockton VNA sees tremendous opportunity for certified home based providers, including us, to contribute more to the Commonwealth's efforts to reduce the use of the emergency departments and in-patient care for patients with behavioral health diagnoses. With a shortage of facility-based beds and other options for treating behavioral health conditions, certified home health providers should be leveraged to help teams of providers and other support services to deliver care where patients reside. Treating behavioral health conditions and the physical health conditions on the same visit would be a best practice standard that can be replicated across the Commonwealth.
b. Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.
   The Brockton VNA has criteria in place for a "Call Us First program". This entails a home visit to assess and try to prevent a trip to the emergency department by treating the patient at home in consultation with the physician, or to have the Nurse Practitioner make a home visit.
c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.
   Not enough experience to provide the information requested.
d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.
   The BVNA would need to analyze requests to determine our ability to report discharge data. The BVNA and certainly others, stand ready to work with the HPC to address gaps in services and access so that behavioral health care can become more integrated, coordinated and cost-effective.

12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.

Summary: As an independent certified home health agency not affiliated with any system, the number of patients linked with a PCMH cannot be tracked. Therefore, BVNA cannot provide a sufficient analysis on the impact on outcomes, quality or cost. BVNA has been in discussions with a potential PCMH. It would be valuable if the idea of certified home health care could be an extension of the PCMH future certifications.

a. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?
b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?

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c. Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and costs of care.

13. After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.

Summary: In terms of post-acute data, it is not a surprise to see that Massachusetts exceeds national averages when it comes to patterns of service utilization. The use of post-acute services may well tell a positive story, as it fits with the high degree of attention to assuring that all patients have a safe discharge plan. Certified home health care is often cost effective in comparison with other formal post-acute settings so the fact that referrals are high may equate to a model for efficient care.

Answer: Brockton VNA applauds the HPC for putting long term care on the health care agenda. The report raises many questions that the Commonwealth has been grappling with for years in terms of long term care usage, benefits as well as spending in the community versus on institutional services. Questions for further examination are: How much of the variation between MA and the nation, in the community based services sector, is attributable to a state plan that has been described as "rich" in certain benefits compared to other states in terms of services covered and in its income qualifying standards? How or why, despite a policy of Community First, and a doubling of the participation in the MA self-directed personal care attendant program, does MA have a 46% higher nursing home residency rate than the US? How do patients with behavioral health diagnoses factor into the utilization and composition of long term care services? What is the longer term trajectory of this spending? How would it look if MA was at the top of the states in terms of % spent in community versus institutions, rather than in the middle? Ways of paying for Care Transitions and coaching visits as a way of reducing ACH rate.

I am legally authorized and empowered to represent the Brockton Visiting Nurse Association, Inc. for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury.

Beverly Pavasaris
President
Brockton Visiting Nurse Association, Inc.

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Appendix

Appendix 1:

The third trend is the competition from home care organizations who are a part of an ACO. They have a presence in the "acute care facility" denying patients a true choice in services (which is a Medicare Reg.), because "they are from a pioneer ACO".

The fourth trend is that Massachusetts is one of a few states that does not have a Certificate of Need program to establish new certified home health agencies to start in MA. This is out of control not only for home health care, but also for hospices. The Home Care Alliance of Massachusetts has lobbied to get bills passed for a CON process to no avail.

Part of the strategic plan for the average daily census was "growth". This was accomplished in 2011 with a 13.7% growth. Then that growth began to drop in 2012 to 12.9%; in 2013 the growth dropped to 1.7%. In 2014 it remains flat. The actual admissions from 2010-2013 had a growth of 0.3%. Medicare admissions during the same time frame grew by only 1.4%. Visits are up from 2010-2013 as patients are sicker, and need more care. That increase was by 34%. Expenses are up with salaries and wages during 2010-2013 due to the need for more provider staff, contracting for staff to cover vacancies, health insurance cost for employees, and the union environment!

Appendix 2: Elimination of the 13th, 19th and 30 day reassessment visits for patients receiving rehabilitation service. This is an unnecessary, cumbersome process for the professional Physical Therapists, Speech and Language Pathologists and Occupational Therapists. These professionals are educated, work by their code of ethics and are all licensed. This process takes away from patient time and adds to the visit cost.

This Medicare regulation occurred after proprietary home care organizations were caught over visiting. As a result of this all certified home health agencies are being penalized.

Appendix 3: Many of these unaligned agencies are community visiting nurse associations that have the greatest experience serving patients with the most complex clinical and socio-economic circumstances. These VNAs have strong local connections, provide significant free care that is not tracked in any community benefit database, conducts public health clinics, administers flu vaccines and conducts community education, and provides free care to patients in their homes.

The Brockton VNA would like to see the HPC encourage innovative contracting arrangements between multiple community/safety net hospitals and community certified home health agencies, as long as such agencies meet quality standards.

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The Brockton VNA would like to see APM contractors track the use of home health care services to see how their use impacts both patient costs and outcomes.

Certified home care providers are ideal to serve as an extension of the patient-centered medical home where APM's could come into play. Certified home health care providers independently or in collaboration, are well positioned to earn APM's for telehealth services where an episodic payment could cover telemonitoring services as well as telephonic and in-person follow up.

Appendix 4: CMS requires certified home health organization to have a "vendor run" patient satisfaction program. CMS approved those vendors. The yearly cost for the BVNA is over $5000.

Appendix 5: As a way to maintain strong community service delivery, BVNA does recognize and supports the Community Health Care Investment (CHART) grant opportunity, and believes its efforts to advance health and promote technology through connecting these hospitals with community partners has the potential to strengthen and expand the use of community hospitals and the services provided by community partners such as the BVNA.

To increase a commitment to lower cost community care the BVNA suggests that the HPC consider initiating, in parallel fashion to the community hospital work, the following:

- A study of home health, including a capacity and needs assessment; the impact on the industry of changing payment models; the adoption of innovative care models, such as remote monitoring that are enabling better patient care, and the degree of **community benefits provided by certified home health agencies that support population health and are at present not captured in any public report.**
- A CHART-like grant support process that would identify essential community based providers and provide them assistance in: delivery transformations and care transitions, readmission reduction work, expanding behavioral health care at home, adopting electronic health records and information exchange among providers and working with APMs and coverage for highly skilled programs that are not recognized by insurers.

Appendix 6: with a chronic medical condition, but no behavioral health conditions." Moreover, the report notes that "reducing the rate of hospitalizations and ED visits by providing care in lower-intensity settings may represent a significant opportunity to improve care while reducing costs for this population."

Given the fact that the BVNA has 24/7 availability and more than a century of experience in treating vulnerable populations in their homes, we have the ability to become part of a behavioral health continuum of care.

Beverly Pavasaris
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