VCDR
VERMONT COALITION FOR DISABILITY RIGHTS
Nothing About Us Without Us

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Date: January 24, 2014
To: Vermont Legislators
From: The Vermont Coalition for Disability Rights
In Re.: ACOs and Long term Care

Last August as Vermont was considering what should be included in our Request for Proposals regarding Medicaid Accountable Care Organizations, VCDR submitted the attached letter to remind the State Innovation Model Steering Committee (now the Vermont Health Care Innovation Project Steering Committee – VHCIP) of the important differences between acute and long-term care, and potential pitfalls if ACOs are not properly structured and regulated.

There are tremendous benefits to be realized if different kinds of health care are better coordinated and we could all benefit from cost containment. We still believe, however, that there are different imperatives to be considered in delivering long-term care and the services that make it possible to live successfully with a disability in the most integrated setting. The State's role is critical in ensuring that these imperatives are protected in any policy or contract decisions relating to the role of both ACOs and Vermont's designated agencies providing disability and long term care service and supports.

Thank you for reading the attached letter and for helping to insure that all Vermonters have equal access to opportunity, even those with long-term care needs.

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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.

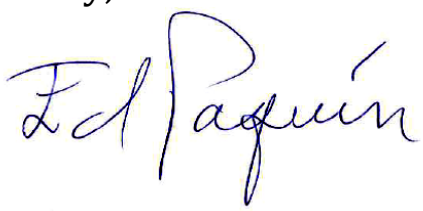
If your only tool is a hammer, everything looks like a nail. If hospital-based ACOs become the state's central mechanisms for cost containment in Medicare, and especially Medicaid, it doesn't take a lot of imagination to see an erosion of support for our long term care services. Even if institutions 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