

Creating Choices

*Reforming Vermont's Home Health Care Regulations to Put
Customer Service Ahead of Provider Protection*

January 2004



An Ethan Allen Institute Report

Creating Choices for Home Health Care Consumers

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Executive Summary

Since 1906 Visiting Nurse Associations have provided valuable and much-appreciated services to homebound, sick and disabled Vermonters. Initially supported by private gifts and donations, united funds, and town contributions, the VNAs are now largely dependent upon state and Federal reimbursement. In recent years they have exerted great effort to make sure that state and federal laws and regulations protect them from any competition. Indeed, Vermont is now the only state where VNAs maintain an almost total monopoly over services to Medicaid and Medicare consumers.

If those consumers are dissatisfied with the quality of services offered by their local VNA, or unable to get the quantity of service the state has authorized for them, they have nowhere to turn, unless they can afford to pay for their own services.

This report documents the dimensions of the problem facing home health care consumers. It sets forth as a goal expanding choices among more qualified providers for independent consumers with the knowledge to exercise sound choices about their care, and offers seven specific recommendations toward that end:

1. State regulators should allow home health eligible consumers to contract with independent registered nurses for Medicaid and Medicare reimbursed services.
2. The legislature should repeal the Certificate of Need requirement for home health care, and replace it with provider screening and licensing, with conditions regarding charity care.
3. The legislature should give BISHCA the authority to license small home health care and personal care providers.
4. BISHCA should identify and contract with a private, nonprofit entity to survey and accredit small home health and personal care agencies.
5. The State should continue to fund the assistive technology portion of Medicaid waivers.
6. The State should codify in regulations that hospital discharge planners shall inform departing patients of the available choices among home health care providers.
7. The Governor should require all relevant state agencies to post information on home health care providers on their websites.



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Introduction

Wheelchair-bound Scott Goyette of Burlington often can't get dressed in the morning to get to work. Why? Because Vermont still uses an archaic regulatory process called CON – Certificate of Need. It's the only state in the union that still uses the CON process to protect a monopoly for certain favored providers, the state's Visiting Nurse Associations. Only these 12 regional VNAs are allowed to provide home health services to Vermonters eligible for Medicaid and Medicare.

"I need to get up at 6 a.m. to get everything done to get to work on time. What happens now is, the Visiting Nurses say, '7 or 7:30 a.m. the best we can do, unless someone volunteers to do your care.' This comment enforces the idea that my life is a favor," Goyette said.

"I used the (VNA) service for 12 years before I disengaged from it. There are a lot of wonderful people, but the culture sets people up to fail. It doesn't allow for innovation and there isn't a lot of adaptability. The experience reinforced for me that real choice in home health care is not about creating agencies that will operate similarly to the VNA, but choices that empower the consumer."

Goyette, like thousands of other Vermonters dependent on home health services, knows the VNA is Vermont's only provider of services to most Medicaid and all Medicare clients. Unless he can pay out of pocket, Scott Goyette has no other provider to call. The Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), alone among the states of the nation, has interpreted its Certificate of Need (CON) law to limit reimbursement for Medicare and Medicaid home health care services to eligible Vermonters to just one favored home health provider per region.

"The single provider doesn't have wiggle room, so they get caught up helping whoever is making the most noise. They are constantly putting out fires," said Goyette. "Everyone ultimately would be happier if they opened it up to competition. Services would be adapted to better meet consumer's needs."¹

Confirming Goyette's conclusion, business strategy expert Dr. Michael Porter of Harvard Business School writes, "In industry after industry, the underlying dynamic is the same: competition compels companies to deliver increasing value to customers. The fundamental driver of this continuous quality improvement and cost reduction is innovation....Inevitably, the failure to promote innovation will lead to lower quality or more rationing of care - two equally undesirable results."²

Opening Up the System

But opening home health care up to competition and innovation hasn't been easy. Consider the experience of Sterling Services, a nonprofit agency serving Vermonters with developmentally disabilities.

Two years ago the mother of a severely disabled child approached Sterling Services, asking if it could provide her son critically needed home nursing services. Johnny Doe was stuck in the hospital, as no home health agency was able to provide the home nursing that was needed. Hospital discharge planners had reported the mother to Social and Rehabilitation Services (SRS) for neglecting her son by leaving him in the hospital. When she had Johnny admitted to the hospital for respite care, she had said, "I'm not taking him home until I have nursing care, I can't do it anymore."

Knowing the Players: A Glossary of Acronyms

BISHCA: The Vermont Department of Banking, Insurance, Securities and Health Care Administration.

CMS: the Center for Medicaid and Medicare Services, the division of the U.S. Department of Health and Human Services that administers those federal programs.

CON: Certificate of Need, required of home health care agencies as well as hospitals, clinics, nursing homes, and stand-alone surgical facilities. CON approval is granted by the Commissioner of BISHCA after recommendation by the Public Oversight Commission.

DAD: The Vermont Department of Aging and Disabilities, in the Agency of Human Services.

JCAHO: The Joint Commission on Accreditation of Healthcare Organizations: A national accrediting body for home health agencies, hospitals, and other health care agencies.

LNA: Licensed Nursing Assistant, certified by the state Board of Nursing.

NAHC: National Association for Home Care and Hospice, founded in 1982 to represent home health care agencies in Washington.

OASIS: Outcome and Assessment Information Set, the federal data base for home health care information.

PATH: The Vermont Department of Prevention, Assistance, Transition and Health Access, the department within the Agency for Human Services that manages Vermont's social welfare and Medicaid programs through its Office of Vermont Health Access (OVHA).

PCS: Personal Care Services, a PATH home health care program serving children. "Personal care" is also a term used to distinguish services that are non-medical and typically not provided by a nurse.

PNS: Professional Nurses Services, Inc. a Winooski-based statewide private provider of home health care services (see sidebar on page 9.)

POC: Public Oversight Commission, the 13-member state commission that reviews applications for CONs and other health care budgets. (Located within BISHCA)

RN: Registered Nurse, licensed by the state Board of Nursing.

SRS: The State Department of Social and Rehabilitation Services, that deals with dysfunctional families, placement of foster children etc.

VAHHA: The Vermont Assembly of Home Health Agencies, the trade association for the 12 VNAs and their legal advocate and lobbying voice.

VNA: Visiting Nurse Association, the generic name for 12 regional nonprofit agencies that provide home health care and other services in their respective service areas. (VNA also stands for Visiting Nurse Alliance of Vermont and New Hampshire, and Visiting Nurse Alliance of Chittenden/Grand Isle Counties, two of the 12 regional VNAs.)

Hiring a nurse to oversee Johnny's home health services "was a political and legal nightmare, but we pulled it off," said Kevin O'Riordan, Sterling's executive director. "We were able to work out a deal with PATH (Vermont Medicaid) where we would provide delegated services through a registered nurse we hired as a medical coordinator, and they (Medicaid) would pay. It is an exception to the rule, going on for two years now, and it is quite successful."

Operating essentially as a home health provider without a certificate of need, Sterling Services employs a nurse for 25 hours a week. She trains and oversees the caregivers serving the boy. The caregivers working under the nurse's license are not themselves nurses or licensed nursing assistants. The state Board of Nursing also issued an exception to allow delegation to non-licensed staff to provide care, O'Riordan said, adding, "We don't need a nurse for everything." Without this off the books arrangement, the child would either have stayed in the hospital or moved to a nursing home.³

To legally provide home health services, Sterling Services should have applied for a certificate of need (CON) from Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). But obeying this law would have sentenced Kevin O'Riordan to a legal and political nightmare of epic proportions, and Johnny Doe to a life in a hospital or nursing home.

Vermont's home health system of certified Medicare-Medicaid agencies is a closed shop controlled by 12 non-competing Visiting Nurse Associations. Since 1979, when the CON process was first created, no other entity has ever been granted a CON to serve Medicare and Medicaid clients in their homes.

Living within this restrictive law is becoming harder and harder for Vermont home health consumers, particularly those individuals like Scott Goyette who seek innovative providers. Voices within the disabled community are calling for choice. Sterling Services is not alone in seeking a way to skirt the CON process to bring competition to the monopoly providers.

Citing the value of continuity of care, families of patients rehabilitated at Pleasant Manor Nursing Home in Rutland asked nursing home administrator Joseph Tolpa Jr. to send their soon-to-be-discharged loved ones home with services provided by the nursing home's resident therapists. In 1998 Pleasant Manor sent a letter of intent to BISHCA, stating it wished to begin providing therapy services to patients discharged to private homes. BISHCA ultimately ruled that a CON was required, though the facility was not planning to expend \$300,000, the threshold triggering CON reviews for new institutional services.

Well aware that BISHCA would not grant them a CON for home health services, Pleasant Manor did not pursue the matter. But five years later the state (through the Department of Prevention, Assistance, Transition and Health Access, PATH) issued a provider change memorandum "allowing nursing homes to provide outpatient rehabilitation services: Physical therapy, occupational therapy, and speech to our beneficiaries who have recently left the home. This is to ensure continuity of care."⁴

Continuity of care is the reason given for another pair of "exceptions to the home health agency rule" currently funded by PATH. Two families with children similar to Johnny Doe were unhappy with the parade of different nurses arriving at their home every day. They proposed an innovative idea to PATH's recently retired program director, Paul Wallace-Brodeur. They would self-manage their children's cases, contracting with an independent nurse who was not an employee of a home health agency.

One family was granted permission in 2000, a second in 2001. Today, both families remain weaned from the VNA, and continue to self manage their children's care. Having provided the

contracting nurses with Medicaid provider numbers, PATH continues to pay for the care. Prior to the nursing shortage, it is estimated one family saved the state about \$40,000 a year with such an arrangement. Today, they are wrestling with continuity of care issues themselves.⁵ The arrangements are referred to as the “High Tech Pilot”, though there is nothing in writing at PATH about the pilot, or how or when it will be evaluated.

In yet another end run around the CON process, the Department of Corrections has contracted with a private, for-profit nursing service to provide care in the state’s correctional facilities. Vermont Medicaid law governing home health care states that “The service is provided in the beneficiary’s place of residence.”⁶ State regulators, perhaps with their fingers crossed behind their back, claim that while the prison is a home, the private nursing service does not need a CON because prisoners are not receiving services in their bedrooms (cells).

BISHCA acknowledges that “over time other organizations have requested authorization to become home health agencies and receive Medicare certification as well. In making the arguments for obtaining authorization issues regarding competition, choice and anecdotes that high-

Visiting Nurse Associations

The Visiting Nurse movement flowered in the early 20th century, with society’s concern about caring for sick family members in their homes and improving physical and moral hygiene, especially among poor immigrants. The first VNA in Vermont appeared in Burlington in 1906.

As hospitals came to dominate the health care system in the 1940s and 1950s, the VN movement slowed. The advent of Medicare and Medicaid in 1965, underwriting the cost of some home health care services for seniors and the poor, sparked new growth. Since these programs initially limited reimbursement to nonprofit organizations and state agencies, there was no competition from proprietary companies, and the nonprofit agencies informally created exclusive franchise territories.

In 2001 there were 12 Medicare-certified home health agencies in Vermont. All 12 were independent nonprofit agencies. Five agencies (Chittenden, Visiting Nurse Alliance, Rutland, Bennington and Southern Vermont) had legal affiliations with local hospitals. Caledonia HHC is legally affiliated with Northern Counties Health Care. Eleven agencies are accredited by the JCAHO, and one by the Community Health Accreditation Program. In 2001 the VNA agencies made nearly 1 million visits to over 23,000 Vermonters.

In addition to their reimbursement from private insurers and from Medicare, Medicaid and other public programs, VNAs traditionally appeal for contributions from town governments through articles on town meeting warnings.

The VNAs, through their trade association VAHHA, have steadfastly opposed any competition in publicly supported home health care services. Its position was stated clearly by its attorney Philip White at a POC hearing (11/5/03): “If you find a better system that will better serve our communities, we’re behind you. But we haven’t found that system yet. And until we have, we will make money in a competitive environment or a noncompetitive environment, but until we see a better system, we are not going to go down without a fight.”

With respect to the 2003 PNS application to use LNAs in the HiTech program, the VNAs proposed the condition that PNS’ entire CON should be immediately suspended if PNS even applied to any federal or state program to serve Medicare clients without first getting an expanded CON from the state. (Web site: www.vnart.com.)

light problems individuals have had with services have been presented and debated in several forums. Proponents of additional agencies assert that the addition of competitors would provide an environment in which costs would be reduced and quality of care improved while consumers would have the advantage of a choice of provider agency. No party has presented objective information to effectively demonstrate the existence of systemic problems involving either quality or access to medically-necessary services under the current system”.⁷

Vermont’s powerful Visiting Nurse Association trade group, the Vermont Assembly of Home Health Agencies (VAHHA), has long and successfully maintained that opening up the marketplace to other providers would be disastrous. Commenting on the staffing shortages like those Scott Goyette experienced, VAHHA claimed that “competition would not alleviate this problem, it might actually exacerbate it (1) by increasing expenses as a result of competition for employees (2) by the inefficient use of the staff that is available and (3) by removing the obligation accepted by agencies in the present system to serve all in need.”⁸ Point (3) is often referred to as the Anti-Cherry Picking Argument.

Assuring Quality Through Competition

Beginning in 1974, the federal government mandated that states establish CON processes to prevent the same three outcomes the VNA warns about: escalating healthcare costs, duplication of services, and cherry picking by competing providers. Though home health was not originally a service covered by these federal health planning mandates, 38 states and the District of Columbia chose to include it in their state CON laws.

By 1986 the CON process had proven a failure at achieving its intended purposes. The federal government stopped funding CON programs and repealed the mandate. States began to drop the process. Today, 20 states have repealed CONs for home health and 12 states never instituted regulation.⁹

“CON regulations, by reducing competition and consumer choice, inhibit market mechanisms that are vital components to the current health care system. Furthermore, a review of the literature clearly establishes that CON regulations have not achieved the forecasted reduction of overall healthcare costs, nor have they improved quality of healthcare,” maintained Robert J. Cimasi, president of Health Capital Consultants, St. Louis, MO.¹⁰

Cimasi continued, “Competition compels providers to control costs and provide quality service. This competitive system is the basis for cost control in the U.S. economy. CON is an artificial, government imposed barrier to competition rarely seen in the U.S. outside of the healthcare industry.”

In Maine, the state dropped the CON requirement for home health services in 1991. Medicaid expenditures for home health actually dropped. A major reason was the substitution of health care aides for the RNs formerly required by the law. The number of providers grew by less than two percent.

“We couldn’t frankly find a compelling reason for why we had a CON for home health in the first place, “ said William Perfetto, Maine’s CON director and assistant director of reimbursement. “We knew that competition was the only way to really assure quality.”¹¹

The Effects of CON

A Northwestern University study surveyed the hospital records of more than 200,000 patients in 45 states. It found that states with the most stringent CON regulations – controlling the ability of hospitals to expand and purchase equipment – had mortality rates 5-6 percent higher than states with less stringent CON regulations. The authors concluded that severe regulatory requirements “create incentives for hospitals to contain costs and may act as barriers to the development of innovative services that might otherwise improve the quality of care.” (Shortwell and Hughes, 318 *New England Journal of Medicine* 1100, 4/28/88.)

Like neighboring states, Maine was looking for ways to reduce the nursing home population in the late eighties and early nineties. Lawmakers agreed to the idea of shifting more of the long term care population from nursing homes and even put a moratorium on the construction of new facilities. But they added one caveat to the law: the home health market would have to open up to competition. The certificate of need was eliminated and proprietary agencies were for the first time allowed to compete with VNAs.

A similar effort to expand the range of home health providers in Vermont failed during the debates and passage of Act 160 in 1996, the law which began to shift the balance of long term care resources from nursing homes to home based settings.

In the 12 years since this change in Maine's regulation of home health, Maine has seen agencies close due to a lack of business, increased competition, and state sanctions around quality issues. In 1990, the state had 22 agencies; in 1991, 35; 1994, 29; 1997, 53; and in 2000, the number dropped back to 1991 levels, 36.¹² Clearly, deregulation didn't lead to rampant growth, and some of the changes are the result of existing agencies either adding or reducing branches.

State regulators are pleased that dropping the CON also led to a reduced Medicaid home health care budget in Maine. "We pushed for less money to go to home health nursing and more to private duty and personal care attendants," said William Perfetto. By moving to two levels of licensure rather than one, Maine saw the Medicaid budget of dual service agencies go down, presumably because more services were provided to the Medicare population. The state licenses agencies for billing Medicaid only, and as dual licensees (billing both Medicaid and Medicare.)

In her 1995 review of Maine's transition to a CON-free home health market for the Vermont Health Care Authority, Leslie Linton talked to health planners and found that "quality is perceived as better; access in rural areas of Maine is far greater; and prices charged by non-profits and for-profits are similar, if not identical."¹³

In 2003 the state of Maryland contracted for a significant CON study, and similarly discovered that the, "CON does not appear to affect negatively home health agency population-based use rates...the number of home health patients and home health visits per 1000 appear to be higher in states with CON regulation, compared to those who eliminated regulation and those who never regulated."¹⁴

Further, "Overall costs...and expenditures per (home health) patient do not appear to be affected by CON regulation."¹⁵ As Robert Cimasi puts it, "CON serves to promote the oligopoly interests of existing, established provider organizations who find competition inconvenient."¹⁶

In May 2002 VAHHA, Vermont's home health trade association, testified about the monopoly-enforcing power of the state's CON. "The 1999 CON guidelines support the retention and protection of this system from competition by new for-profit and not-for-profit agencies," VAHHA stated.

VNA's reference to the "CON guidelines" is significant. State regulators have historically included four points when considering CON home health applications: 1) reasonable access to needed clinical services; 2) no unnecessary service duplication; 3) review of new services; and 4) control of capital expenditures. Developed informally over time, these four defining points have never been codified. In fact, the only statutory language governing CON for home health agencies appears in the portion of the law that identifies what triggers a CON review. "All we have is just those five little words," said Donna Jerry of BISHCA, "any new home health service."

The VNAs collectively reported growth in home visits of close to 20 percent a year through the 1990s. But since the CON was introduced in Vermont in 1979, it appears that only two new

Professional Nurses Service Inc.

As an intensive care nurse at the Medical Center Hospital of Vermont in 1980, Jean McHenry RN conceived the idea for Professional Nurses Services Inc. At the time, the VNAs offered nursing visits only, with no extended hours, weekend, night or holiday care. Despite strong opposition by the VNAs, PNS got CON approval in December 1980, but the organization was limited to providing nursing (RN and LPN) services only. PNS could hire LNAs, but they were not allowed to provide services to consumers for which they are trained and licensed. If the CON allowed PNS to make full use of the skills of LNAs, PNS would qualify to apply for Medicare-certification as a home health agency under federal guidelines. At the urging of VAHHA, state regulators wrote PNS' CON specifically to prohibit PNS from ever seeking Medicare-certification and thus becoming a full service home health agency.

In 1987 by the state and a durable medical equipment provider approached PNS with a request to provide nurses for a "High Tech Program" that would allow technology-dependent children and adults to leave hospitals and nursing homes and be cared for at home. PNS became the first home care organization in Vermont to earn JCAHO accreditation to provide these services. About four years after the High Tech Program began, the state approved the VNAs as High Tech providers even though not all had achieved accreditation at that time.

In 1991 McHenry suggested to Health Commissioner Jan Carney that less expensive LNAs be used to provide some of the High Tech care as a means of saving taxpayer dollars. McHenry recalls Carney saying she would agree to this CON change, but only if PNS agreed never to seek Medicare certification. McHenry declined.

In 2002 a serious nursing shortage prompted PATH to issue a memo stating that High Tech providers could make use of LNAs or even unlicensed caregivers. The VNAs could therefore send any staff person to provide care. But because of its CON restriction, PNS still could not use LNAs in the High Tech Program, even though PNS trains LNAs for all other providers. PNS is restricted from providing full-service LNAs to even private pay and privately-insured clients.

PNS brought a federal court action in 1991, asking to be allowed to fully use LNAs in its employ without further CON review. The court rejected the petition, deferring to the state.

In 2003, with the nursing shortage at crisis proportions and the PATH High Tech memo in hand, PNS applied for an amended CON to allow it to use LNAs only for the High Tech Program - to the benefit of fewer than 200 children and adults statewide. No capital expenditure was involved with this request. The VNAs, the only other providers on the program, strongly opposed PNS's CON change. Its 144 page brief argued that if PNS persisted in seeking to provide additional services, its entire CON should be revoked.

On December 3, 2003 the Public Oversight Commission voted unanimously in favor of the PNS application. BISHCA Commissioner John Crowley will make the decision in January 2004.

The Winooski-based PNS has about 200 full and part time employees.

providers of home health care services have been granted a CON. One was Professional Nurses Service, in December 1980. The CON limits PNS to offering only nursing services delivered by RNs. (The other, HHNS of Rutland, folded in the 1990s.)

Amazingly, no new full service home health agency that would compete with any VNA has ever been approved. No new hospitals have been started in Vermont, other than through mergers. About 10 new nursing homes have appeared, through merger of older ones or construction of replacement facilities. No new ambulatory surgical facilities have been opened.¹⁷

Informed Consumers: Controlling Costs and Assuring Quality

Rather than relying upon government to screen and authorize providers through the CON process, most states are placing their faith behind informed consumers making sound judgments about where to go for care.

However, getting adequate information to home health consumers is a significant problem. “In rating restaurants, hardware stores and prices on the shelf, consumers find it easy to obtain information,” said Thomas R. Piper, director of the Missouri Certificate of Need Program and a member of the American Health Planning Association’s Board of Directors. “We need the right tools and objective data to establish the criteria for choosing a provider and measuring the cost and quality of home health care. Yet, there seems to be a real reluctance to allow data to be collected.”¹⁸

When asked how Vermont’s Department of Aging and Disabilities (DAD) could help consumers learn more about measuring the quality of home health services, Commissioner Patrick Flood said, “We haven’t done much with that. We could put public information on the web. I don’t have a problem with that. To a large extent, I don’t know why we wouldn’t,” he said, noting that information on Vermont nursing home quality of care is posted on the web.¹⁹

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) offers an Organization Accreditation History of its member home health agencies at www.jcaho.org/quality-check/directry/history.asp. The site notes if an agency was accredited with requirements for improvement, with full standards compliance, or with commendation. Individual agency performance reports are also posted. The Discovery Channel’s health grades website (www.healthgrades.com) provides a summary of home health surveys, state by state.

Nationally, the Center for Medicaid and Medicare Services (CMS) has launched a website with home health customer satisfaction information. Several years in the making, the site highlights data from the federal Outcome and Assessment Information Set (OASIS) reports submitted by home health agencies. Called Home Health Compare, the site (www.medicare.gov/HHCompare/home.asp) currently provides data on home health agencies in Florida, Massachusetts, Missouri, New Mexico, Oregon, South Carolina, West Virginia and Wisconsin.

“Quality measures give you information about how well home health agencies provide care for some of their patients,” according to the site narrative. “The measures provide information about patients’ physical and mental health, and whether their ability to perform basic daily activities is maintained or improved. Quality information can be used to help you compare home health agencies.”²⁰

Anticipating Vermont’s data being added to Home Care Compare this fall, Nancy Trombley RN, lead nurse surveyor with DAD’s division of licensing and protection, said “The website will be very client-centered, looking at such issues as timeliness of visits, keeping physicians informed and when the first visit is made after a referral is made.”²¹

Trombley and other nurse surveyors conduct surveys of home health agencies, per federal law. Vermont agencies are not licensed, even though Licensing and Protection oversees a federal certification program. State officials point to the CON and this federal certification when asked why Vermont doesn't issue home health agency licenses.

In the 2003 session of the legislature Rep. Bob Helm (R-Castleton) and others introduced a bill (H. 346) to require licensure of home health care agencies. Several sponsors reported receiving a high level of harassment from the VNA lobby for even suggesting such a possibility.

Surveys of Vermont home health agencies are currently conducted on a random sample of patients, based on a formula in federal law. The nurse surveyors look at patient records and conduct home visits. "If a red flag comes up for us during survey or complaint inspections, we would have contact. We have a whole array of federal enforcement actions available to us," said Laine Lucenti, chief of DAD's Licensing and Protection Division. "In my history, (since 1990) we've never got to that level. We've had deficiencies that have required plans of correction. We have a pretty good track record in our state."²²

Deficiencies cited on home health surveys conducted between 2001 and the present in Vermont include problems with wound care, not following physician orders, suspected abuse, missed visits, therapies not received, staff not completing mandatory continuing education and not following patient's required dietary restrictions.²³

When the federal Department of Health and Human Services surveyed the Visiting Nurse Alliance of Vermont and New Hampshire in September 2002, the findings included this: "Patient No. 2, with a diagnosis of pneumonia, was admitted to the home health agency of 8/18/02. Per interview, the patient/family stated they were told that a nurse would be visiting two times a week. Record review confirmed that from 9/1/02 through 9/7/02, no nursing visits were made, and since that time the nurse had visited once weekly. The family stated they received no explanation why the nurse did not make the visit or why visits were reduced to weekly. In addition, this patient received seven nursing visits since her admission by seven different nurses."²⁴

In January 1998, recognizing it lacked objective information concerning the quality of and access to home health services, BISHCA began collecting data on complaints, waiting lists, number of individuals ineligible for services, number eligible but not provided services, number of people served under and over age 65, and total number of visits/hours provided to clients in the various home health entities operating in Vermont.

The data is submitted to BISHCA on a quarterly or annual schedule depending on the data type, and is used to support the Division's reviews of CON applications relating to the consideration of additional home health agencies.²⁵

BISHCA also monitors the DAD complaint hotline, and initially turns it all over to the existing home health providers to correct the situation, rather than to encourage competition. "If the data collected by the Department identify access, cost or quality issues in any area of the state, the Administration will encourage the agency or agencies with identified issues to remedy them, and will only consider approving additional home health agencies if the problems cannot be remedied in a timely manner."²⁶ In FY 98, 154 complaints were reported to BISHCA; in FY99, 123.²⁷

In the first quarter of fiscal year 2000, BISHCA collected 39 reportable complaints and DAD collected seven. "During this same period, Vermont's home health agencies served over 20,000 patients, providing nearly a million home care visits. Vermont's home health agencies do not treat any complaint lightly. However, the number of complaints is extremely small compared to the number of people served (0.18 percent) and the number of visits provided during this past year."²⁸

Since the 2000 data was compiled, BISHCA reports it has not had the time to compile new data,²⁹ despite the fact that at least one CON application for home health was processed during this time. (Central Vermont Home Health and Hospice applied for a CON for a \$1.5 million headquarters expansion. When the application was denied the agency decided to shave its plans and build for \$750,000, under the CON threshold. The building came in over budget. After the ribbon cutting was held, BISHCA levied a \$1,000 fine.)

What About A Choice of Providers?

A choice of providers is a central value of informed consumers and home health professionals. The National Association for Home Care and Hospice (NAHC), of which the VAHHA is a member, has a Code of Ethics. Within the Code is a section on patient rights and responsibilities. It reads, in part: “It is anticipated that observance of these rights and responsibilities will contribute to more effective patient care and greater satisfaction for the patient as well as the agency. . . .*The patient has the right of choice of care providers.*”

In Vermont, however, Medicare and Medicaid patients do not have this right. “Medicare law is silent on that point,” said Marva Nathan, branch chief of beneficiary and provider services at the Boston regional office of the Center for Medicaid and Medicare Services.

Curiously, Medicare law does speak to choice within the managed care and fee for service programs, according to Ms. Nathan. Within the managed care programs, “Consumers use their feet,” she said, noting, that in the Vermont home health arena, “the consumers have nowhere else to go with their feet,” other than the VNA. Medicare law also provides for providers of care to have a choice of fiscal intermediaries when deciding who will pay their claims.³⁰

Federal Medicaid laws require that beneficiaries have a choice of providers, and also require the state assure the federal government that there are a sufficient number of home health providers. “If the state tells us there is sufficient number of providers, even if there is only one provider, that assures us there is a freedom of choice,” said Chong Tieng of the CMS Regional office in Boston.³¹ This provision is found at 42 Code of Federal Regulations 431.51, “free choice of providers”.

“If they know there is some competition out there, some one else competing for those Medicaid dollars, I think they will try a little bit harder to provide for their clients,” argues Brian Trudo, a client of the state’s largest VNA, the Visiting Nurse Association of Chittenden and Grand Isle Counties. A quadriplegic who needs an average of four hours of care three mornings a week, Trudo says, “We need to be able to call and look at other agencies when the VNA calls and says they are short staffed and can’t send anyone or can send someone only for a few hours.”

Trudo recalls the morning he was insistent about receiving the care outlined in his care plan, which he was entitled to as a Medicaid beneficiary. The VNA administrator told him, “Look, if we can’t resolve this issue, we won’t be able to provide you with services.” Trudo replied, “You’re obligated to provide me with services.” He worries the VNA has “probably used that line with other people. They pressure people and make them feel scared they will lose their services. Often times, people are fearful of expressing their complaints or dissatisfaction because they think it will come back to haunt them, held against them, and because there is no other choice. We need to inform consumers, let older folks know that they don’t need to take what is pushed on them.”³²

During the summer of 2003 Trudo says the VNA informed him it was “having staffing issues and would be cutting all of their level 3 clients (my level of care, spinal cord injuries, Parkinson’s and so on) back to three hours (a day)”. The VNA also told him periodically it couldn’t provide

his range of motion care, suggesting he find someone else. “Depending on my health care aide’s pace, my care can take more or less than three hours. Today, it took five and a half hours, and the aides tell me they are pressured by management to get in and out as quick as they can.”

On a particularly frustrating Saturday, when morning caregivers didn’t arrive until 12:30 or 1 p.m., Trudo called the executive director of the agency at home and asked if he had had his coffee and read the paper. “I told him I hadn’t, because no one had shown up. He told me it wasn’t his problem, and that he had schedulers who took care of this. I told him they weren’t taking care of it. He said, ‘That’s not what I hear.’ I said, ‘Well, you’re hearing it now.’”

In his presentation “Duped by Cries of Duplication: the Failure of CON Regulation”, Robert J. Cimasi warned about just what Brian Trudo experienced. “When patient choice is diminished, decisions about access, quality and beneficial outcomes become the sole purview of these elite groups (business executives and administrators). In the absence of healthy competition, they are free to ignore patient needs and demands.”³³

Brian Trudo and his family would like to have a reputable backup agency to call. PNS serves customers in his town of Essex Junction, but Trudo can’t afford to pay PNS without assistance from Medicaid, and Medicaid (PATH) is not allowed to choose or use both providers.

Families with loved ones in Vermont often learn about the limited home health market during a family crisis. “This past year my parents have aged and needed more care. My family found it difficult to find the assistance they need. I am a clinical social worker with many years working with the aged and disabled,” wrote Madeline Crawford Salottolo, LCSW, of Arlington, VA. “I was shocked and greatly disturbed to find out that there were limited resources available for my parents in the state of Vermont. Only one agency, per county, was allowed or granted the right to provide Medicare services to the aged and disabled. What happened to freedom of choice?”³⁴

Cherry Picking and Unmet Need

Industry spokesmen maintain that ending the VNA monopoly would lead to cherry picking by new providers. In truth, the VNA is actually cherry picking now. It holds exclusive billing rights to the large Medicare home care market, and “Medicare is the true nourishment of home health,” according to John Dick of PATH. The lowest payer is Medicaid, about 29 percent of the VNA income, and 55 percent of the revenue going to the state’s only proprietary agency, PNS. PNS has been able to tap a limited portion of the Medicaid market by qualifying to provide nurses only to two state Medicaid waivers programs, the Traumatic Brain Injury program and the High Tech program. Their limited CON prevents them from also providing LNAs to these programs. (See PNS sidebar.)

While VAHHA and its member agencies beat the “no patient left unserved” drum, consumers of understaffed agencies know differently. During the 2003 BISHCA hospital budget hearings, a Southwestern Vermont Medical Center spokesperson shared the following story:

“A patient was recently admitted into the hospital with a terminal cancer. His wish was to die at home; however, Rutland’s Hospice program would not accept the patient into their service because they determined that the hospice benefits under Medicare would result in a \$3,000 loss in the cost of care, and because Rutland Hospice did not want to take responsibility for the level of care that the patient required at home. As a result, he stayed in the hospital for 45 days until he passed away. The difference between his bill and what the hospital was reimbursed from Medicare was \$18,000.”³⁵ The hospital told this story to bolster its argument for licensing its wholly owned VNA home health agency as a hospice.

Picking a hybridized cherry, some VNAs currently refer hospital patients directly to themselves, because many agencies are affiliated with hospitals. This practice is regarded both unethical and illegal. In Maine, regulations state that, “patients in hospital must be offered a choice of home health providers, at time of discharge, and the hospital must disclose any ownership interest to the patient.”³⁶ Maine has simplified codified federal law, which also calls for such behavior by hospitals. PNS claims Vermont’s hospitals are not affording patients this practice, but rather routinely referring to the VNAs.

Fletcher Allen Health Care, the state’s largest hospital, has recently identified making patient choice important, “Over the past year, the offering of choice has been an area of significant emphasis for me and my staff since patient choice is a foundation of the case management process,” says Dr. Merle T. Edwards-Orr.³⁷

VNA also uses its preferred status to plead its case at town meetings across Vermont. Since the 1980s, the VNAs have netted \$1 million or more each year through this rite of spring. The case made to voters for supporting such hefty donations mirrors the old CON arguments and the anti-competition chant; *we take care of everyone, regardless of their ability to pay*.

But everyone is not being taken care of, as Scott Goyette, Brian Trudo, Johnny Doe’s, and others can attest. “We have always identified unmet need when people can’t access services,” says PATH’s health planner John Dick. Unfortunately, there is no statutory standard for “unmet need”, so CON applicants have no objective test that would support their applications.

Among the steady stream of home health clients seeking care in Vermont are those disabled adults served through two Medicaid waivers, known as 1915 and 1115. For the past three years, data indicates upwards of 25 percent of the care approved for these consumers has not been accessed by eligible consumers.

In FY 2002 reports produced by the Department of Aging and Disabilities indicate that 77 percent of the home health hours approved for VNA delivered personal care in the home and community based waiver were delivered.

“We look at what is not getting done, and process occasional complaints,” said Bard Hill, chief of home and community based services. “Health and welfare needs to be protected. We want to make sure an Agency is making every reasonable effort to deliver services. But across the board in all programs, people are not getting 100 percent of their hours.” Hill added that the Department has no written guidelines or thresholds against which they measure the undelivered hours data. DAD also has no plans to put the data on the web or match it up against its own Division of Licensing and Protection’s home health agency surveys. At this point, the data is distributed internally and to VNAs and Area Agencies on Aging, the latter often providing case management for waiver clients.

In 1997 economist Dr. Phyllis W. Isley of Waterbury submitted testimony to BISHCA supporting competition in home health services. She asked “What cherries are there to be picked? PNS can, and does, already compete in the high-end market for private pay and private insurance clients...The cherry picking argument applies only where there is lax regulation. In a system which has a take-one-take-all rule, meaning that a provider cannot discriminate against clients on the basis of acuity or problem or place of residence, there will be no cherry picking.”³⁸

Choice In Some Programs But Not Others

Throughout the United States, for more than 15 years groups of disabled individuals have become increasingly vocal about wanting a nonmedical model of services, that they can control. “We are not cases to be managed, we are people living lives,” has been their cry. Rather than see-

ing themselves as patients, disabled clients of home health services regard themselves as people consuming a service, and ask providers to see them accordingly.

In Vermont, a choice of providers isn't permitted in the CON protected home health arena, where nurses typically deliver the care, but it is allowed in the totally unregulated home care market, where aides and unlicensed individuals provide personal care.

For all the scrutiny brought to PNS by the VNA and state regulators, the state of Vermont's lax treatment of dozens of private duty nursing services and home care agencies is striking. No laws governing personal care, whether about health planning or quality of care, appear in the Vermont statutes. Yet, it has been seen nationally that such agencies often attract individuals who have been prohibited from working in other settings, due to a loss of license, commission of a crime or other black mark.

Within the state's two major home personal care programs (serving disabled children and adults), "growth in both programs for the last several years has been in consumer or family directed services. VNA volume has been roughly flat in both programs, as well," said Bard Hill of the Department of Aging and Disabilities (DAD).³⁹ Consumers are clearly taking advantage of the limited choice of providers, albeit not nurses, that these programs permit.

Vermont's Department of Developmental and Mental Health Services, PATH and DAD/Vocational Rehabilitation operate eight separate Medicaid programs providing some form of home care: the Traumatic Brain Injury Program, High Tech Program, High Tech Pilot Program, Children's Personal Care, Attendant Services, 1915c Home Based Medically Needy Waiver, Developmental Services Waiver, and the upcoming Cash and Counseling 1115 waiver.

Only the High Tech programs use nurses and LNAs for delivering services; all other programs use unlicensed individuals. Within the High Tech programs, the VNA and PNS are providers, but only the VNA is permitted to use LNAs. (This discrepancy is the basis for PNS' 2003 application to amend its CON, see PNS sidebar.)

The Traumatic Brain Injury program offers a choice of 19 provider agencies to its clients. "Our program has a mandate that there has to be choice. We are very big on that," said Lorraine Wargo, program coordinator. Approved enrollees are sent "a list of providers who could meet their needs and a list of suggested questions to ask those providers. The choice goes both ways. The provider has to have a choice in saying they can't serve the individual," Wargo said.

When agencies refuse a client because of their particular care requirements, which is rare, a referral is made to a competitor known for having strength in that service. Agencies "are competitive, but they have a collaborative relationship, it is not antagonistic in any sense," said Wargo, adding, "There are lots of people to be served and providers can't be all things to all people."

A strong proponent of consumer voice and choice, Wargo maintains it is "better for the consumer to have choices. Choice is not only mandated by the feds for this program, but we found it provides much better quality of services for individuals." When asked about why her program is required to offer provider choice, while other home health services in Vermont offer no choice

Cash and Counseling

An Arkansas demonstration project gave cash and counseling to 1,000 people in the Medicaid personal care services program, and let them use the funds to stay at home and improve their quality of life. It found that by the second year higher personal care expenditures by the C&C group were offset by lower spending for nursing homes and other Medicaid services. "States can design a 'cash and counseling' program that meets recipients' needs better at no greater cost per month than historically incurred under the traditional [home health care] agency approach." Dale et al, *Health Affairs*, 11/19/03.

of providers, Wargo answered, “I don’t how they get away with having only a set number of providers.”⁴⁰

The Personal Care Services program for children, run by PATH, serves about 1000 children annually, half of them labeled autistic, most living with their birth families. This entitlement program is “growing by leaps and bounds, with 30 to 50 new children admitted each month,” according to its coordinator, Alexis McLean RN. Children receive personal care, not nursing, from a variety of approved agencies, including the VNAs and PNS. Nursing services required by PCS clients are provided through the High Tech program.

When state agencies were not able to find personal care attendants, McLean urged the creation of a self-directed component of the program that “would give families a better opportunity and more flexibility. It has proven to do just that, though it isn’t free of problems.” Families are able to select and direct their caregivers, while a contracted agency handles payroll. When an enrollee turns 18 or finishes school at 21, s/he applies to one of several home based programs coordinated by DAD or the DDMHS. Because none of the adult programs are entitlements, however, some of McLean’s clients will not have such services after they reach their milestone birthday.

This self-directed care option is becoming more and more popular within state funded programs. DAD has submitted an application for another home based Medicaid waiver to the federal government, to create a long-term care Cash and Counseling program for those eligible for nursing home admission who wish to remain at home. The waived service is designed to offer consumer choice, though no official policy has been set about adding more providers for program participants to choose from. DAD Commissioner Flood has said he doesn’t anticipate changing or adding providers not already offering home based services in Vermont.

In early 2003 it appeared that BISHCA was likely to allow PNS to assign LNAs to High Tech program clients, an idea the for-profit agency has floated periodically during the past 12 years. A state bureaucrat, who spoke only under the promise of anonymity, blames the VNA lawyers for preventing consumers of home health services from having a choice of providers, by “running BISHCA’s home health discussions and policies. The ultimate winner would be the patient. At least BISHCA could let Professional Nurses Service use Licensed Nursing Assistants. It would save so much money, and we could cover the needs where we can’t find RNs,” the individual said. “It’s crazy that we can’t at least allow another agency to supply LNAs” to home health clients.

PNS had asked BISHCA for an expedited review of its application to amend its CON, since permitting LNAs to deliver care to High Tech clients involved no new money. That review was denied, and a full-blown review was held.

Home Health Services Operating Outside Vermont’s CON

Kathy McQueen of Thetford has operated Kathy’s Caregivers for 30 years. In advertisements appearing in the Vermont yellow pages, as well as in a brochure, McQueen promotes her business as “providing RNs, LPNs, LNAs, social workers and home care providers with a personal touch.” The agency currently has between 30 and 40 employees.

“The CON doesn’t pertain to me,” McQueen claims. “We go into people’s homes, with nurses and aides. We go with doctor’s orders. Our patients pay privately or with some insurance, because we can’t bill Medicare or Medicaid.”

Kathy’s Caregivers specializes in long term private duty arrangements. It took care of the late actor Charles Bronson, providing him with a nurse in Vermont who traveled to California with

him.⁴¹ McQueen received a letter from BISHCA on May 12, 1997 confirming the Department's request that she inform it if she plans to "change the nature of services provided so that we may determine whether the resulting service structure meets the definition of 'home health agency.'"⁴²

McQueen recalls the request, and even that she was told she had to incorporate as a nonprofit, but insists that the government's requests don't apply to her agency. In a letter to BiSHCA, McQueen wrote "Many people in Vermont have been unable to get the services of the VNA. . . . Another reason for Kathy's Caregivers to help out."⁴³

Donna Jerry of BISHCA said that any entity that offers any one of the identified home health services (OT, PT, Speech, social work, LNA, nursing) and employs the providers of the care needs to apply for a Certificate Of Need. Hearing of yellow pages advertisements for nursing agencies operating without a CON, Jerry said "the problem is we have nothing in the statute that gives us the authority to go after people, and no staff to do so, either."

So who enforces the CON laws? One state official suggests, only half tongue in cheek, that the VAHHA lawyers do.

PNS is attempting to use LNAs, just like Kathy's Caregivers. Yet only PNS has had severe restrictions put on its operations, through a narrowly granted Certificate of Need. PNS has filed complaints with BISHCA about Kathy's Caregivers and other similar unregulated, nursing and aide services since 1997.

BISHCA Commissioner John P. Crowley has responded to complaints about unlicensed operations, stating, "Unfortunately, at present, there is no statutory provision in the CON law that requires the Department of Banking, Insurance, Securities and Health Care Administration, or provides us with the staff resources, to proactively seek out or investigate entities that may or may not be violating Vermont's CON law. Therefore, we will do our best to follow up with as many of the entities as possible that we are not familiar with to determine their level of activity but unfortunately, cannot commit to doing so comprehensively."⁴⁴

In Vermont, personal care agencies that offer nursing services are growing. As totally unregulated service providers, these groups typically advertise in the yellow pages under "nurses" and "home health services". The Vermont Secretary of State website lists another half dozen such trademarked agencies, such as Affordable Angel Home Care Registry of Brattleboro, Loving Hands Home Care Alternatives of Bennington, Guiding Light Home Care of Brandon, TLC Home Care of Proctor and Home and Community Health Care of the Upper Valley of White River Junction. Because no state oversight exists, it is unknown if the personnel hired by these agencies are trained or of good character. Background checks are only required if it is the employing agency's policy.

Researchers for this report identified the following additional agencies advertising in Vermont that they provide RNs and LNAs: the Vermont Nursing Solution of Burlington, Champlain Valley Nurse Referral and Child Care Services of Burlington, Interim Healthcare of Lebanon, NH and Happy Hearts of Salisbury. These agencies would seem to be in violation of current CON regulation.

Robin Jackson operates Happy Hearts Home Care out of her home in Salisbury. At this writing she has 15 clients, and receives referrals from the VNA. "We have excellent references from families," Jackson says. Like Eldercare, she is able to bill long term care insurance policies. "I just have to provide a Licensed Nursing Assistant. That is what the insurers want," she said.

Happy Hearts provides care 24 hours a day, 7 days a week, doing "everything but pouring medications," said Jackson. She refers to her staff as "certified and trained by an RN," though no

such distinction is recognized in Vermont law. She describes the training as “everyone is trained in CPR, nutrition and transferring. We hold monthly training meetings on urine, bowel, bi-polar, different issues.” Caregivers sent out by the agency are considered employees of the agency. Jackson does background checks on potential employees through the state abuse registry, carries worker’s comp insurance, and is “looking at a bond.”

Home Instead Senior Care, a national franchise developed by the creators of Merrie Maids, opened its Vermont office in South Burlington in March of 2003. Headquartered in Omaha, Nebraska, it is the largest non-medical franchise in the U.S., with more than 400 offices in the U.S., Canada and Japan. Owner-operator Patrice Thabault says she works with the VNA. “We don’t do any direct handling of medication. We can only remind clients. The VNA will come in and set up the meds for the week.” The service employs its caregivers, insures drivers, does background checks, and provides ongoing training.

Thabault and her sister Paulette became involved with the home care business through caring for their mother, who has Alzheimer’s. In July 2003 Paulette Thabault RN, JD was named deputy commissioner of BISHCA, and has divested herself of her interests in Home Instead.

Martha Miller, owner operator of Eldercare, Inc., a proprietary professional companion service operating in Addison and Windham Counties, is concerned about her competitors. “We require our employees to complete a 60 hour training course, which is taught by experts,” Miller said, “There are hundreds of unqualified people going into peoples’ homes. Some groups are hiring people off the street, without any training or background checks.”

Subjects covered in the Eldercare training include how to accompany a client to the doctor, how to make sure new medication is added to the client’s routine, toileting, transferring, bathing, dressing, and feeding. “We work with the assistive activities of daily living,” she said.

Miller works closely with the medical community, receiving clients from VNA and physicians. “We’re not medical, we don’t need doctors or nurses. But, our employees do know the side effects of medications, and we have our work book, which covers when to call 911 and more,” she adds.

Miller says she has letters from the Vermont Board of Nursing that authorize Eldercare’s operation. She stresses Eldercare is not a referral service or registry, but that she hires, trains and supervises her employees, which is why long term care insurers are willing to pay for her services. Eldercare bills \$19 an hour for individuals and \$22 for couples for a care companion, which can include hands-on care as well as rides to the doctor and driving the client’s car. For a visiting companion with no hands-on care, the charge is \$17 an hour.

Eldercare is reimbursed through privately paying clients and some long term care insurance policies. Plans call for a steady expansion across the state, with Chittenden County being the agency’s next service area. Presently Eldercare has about 20 full and part time employees, who work no more than 40 hours a week each.

Armistead Caregiver Services (formerly Armistead Assisted Living Inc.) of Shelburne also provider caregivers who do nonmedical, personal care for private pay patients. Assistant director Stephanie Victoria says the agency, which opened three and a half years ago, serves seniors and adults with disabilities.

In Maine the state home health inspectors have been interested in regulating such personal care agencies for some time. “They do everything but brain surgery,” says Mary Dufort, Health Service Supervisor. “Every year we get a little closer in the legislature to getting them regulated.” No such movement is active in Vermont.

Where the Money Is

Within the home health/home care/personal care services world there is money to be made. Economists argue that this same profit is ultimately why the CON has such staunch defenders: “What is the real reason why this failed program (CON) has proved so durable and so difficult to eliminate? The answers, of course, are money and the simple, monopolistic desire to restrain trade and increase profits by restricting one’s competitors.”⁴⁵

In its Unified Health Care Budget Forecast for 2004, BISHCA estimates Vermont home health expenditures will be \$91 million.⁴⁶ In figures for 2001, the VNA network of 12 agencies has assets of \$41 million and a fund balance profit of \$21.5 million.⁴⁷ Here is a sampling of VNA assets, as of 2001:

- VNA of Chittenden/Grand Isle counties: \$247,000 land, office complex \$716,733
- Franklin County HHA: \$60,000 land, \$534,148 building
- Lamoille HH&H: \$73,000 land; \$54,000 building
- Rutland Area VNA&H: \$46,500 \$234,922 building
- Addison County HH&H: 48,600 land, \$255,986 building⁴⁸

“The way they choose to manage resources is also a problem. There is a tremendous amount of bloat, too many chiefs, not enough Indians. When you look at what employees get paid and what they bill for services, it is mind boggling,” said Scott Goyette. His comments were echoed by Brian Trudo, who has heard more than one LNA complain about the palatial headquarters of her agency compared to her inadequate wage.

Economist Dr. Phyllis Isley, writing in support of competition in Vermont home health wrote, “The combined monopoly power of these 13 agencies and their corporate status creates the worst possible of all monopoly markets. The current agencies are not only insulated from the need to innovate to improve services, but management is also insulated from its mistakes, and as with most monopolies’ management, is prone to overinvest in capital and administrative overhead... if the home health services market is not opened to competition, Vermonters will have a choice in virtually all markets except for those who receive home health care based on Medicare reimbursement.”

Executives are well compensated, with deferred compensation, 401(k) plans and company cars. In tax year 2001, the head of the VNA of Chittenden/Grand Isle counties was paid over \$105,000. More than the governor of the state. The average compensation of directors of eight VNAs that year was \$81,000.⁴⁹

The Vermont Assembly of Home Health Agencies reported VNA revenues of nearly \$74 million in FY2001: Medicare comprised 48.3 percent of the total home care revenue, Medicaid 28.6 percent, and private insurance 7.5 percent.

PNS reported \$4 million in revenue for the same time period. The amount spent out of pocket by Vermonters for home care is harder to establish.

While each of the 12 VNA agencies has an individual sliding fee schedule, they are similar. Visits are defined as 15 minutes or more with a patient. Charges run from \$95 for an RN to \$155 for a medical social worker. Therapists generally run \$100 per visit, and LNAs run \$40 or more an hour.

Rates for the Medicaid funded home care programs are set on a fee for service basis by the Office of Vermont Health Access (OVHA). Cost reports are no longer submitted by the VNA

agencies, nor does OVHA perform audits. When asked where the scrutiny of VNA budgets occurs, John Dick points to “community boards. We let them do it.”

Home health has been a covered Medicare benefit since Medicare’s inception. Real growth in the business started in 1973, when the younger disabled were added as enrollees. This produced a rapid expansion of growth in the number of agencies: from 1,753 in 1967 to 10,807 in 1997, more than a five fold increase.⁵⁰

While high technology, advances in pharmaceuticals and new clinical practices continued to fuel the home health enterprise, “It became apparent by the mid 1990s that a considerable percentage of the increased demand was suspect.”⁵¹ These suspicions led to the federal government’s Operation Restore Trust, a fraud investigation that focused on California, Florida, Illinois, New York and Texas home health programs.

The result of the federal cleanup was that between 1997 and 1999, the number of home health agencies in the U.S. decreased by 28 percent, and Medicare billing fell by about \$5 billion for the same time period.⁵²

Vermont Largely Avoided the Growth Scandals of Recent Years

Nothing remotely resembling such rampant fraud occurred in Vermont during this time period. Rather, the state experience is that of an industry monopoly. During the big home health boom of the 1990s, Vermont’s home health agencies merged with each other and New Hampshire agencies, created partnerships with hospitals and foundations, and even established their own profit-making subsidiary care agencies. The state’s only freestanding hospice, Respite House in Williston, established by an independent group of citizens, is now a VNA operation.

Incorporated as separate entities, the Vermont’s 12 VNAs also incorporated another nonprofit organization, VNA Health Systems of Vermont. This body negotiates with insurers and other bodies on centralized contracts, and is developing uniform standards for members. The VNAs have entered into mutual no-competition agreements, restricting each agency’s activity to a specific geographic area.

“Because existing home health and hospice services can effectively expand capacity by adding staff, CON regulation does not control their day to day capacity or their ability to meet demand locally,” concluded the AHPA Maryland report.⁵³ In fact, between 1989 and 1993, Vermont’s VNAs increased service visits by more than 20 percent a year, from 311,399 in 1988 to 794,744 in 1993.⁵⁴

The VNA monopoly has been well served by a long standing, cozy relationship with state officials. For example, BISHCA staff held a meeting in March 2003 for VNA representatives to discuss PNS’s application to lower costs in the High Tech program by providing needed services with LNAs. PNS, the applicant, was not invited, nor was the meeting publicly warned.⁵⁵

At that meeting, VAHHA presented a two page position paper that argued: “by allowing PNS to use LNAs, it becomes a ‘home health agency,’ under federal law, eligible to participate in Medicare and Medicaid programs. This would irreversibly and dramatically change Vermont’s present home health delivery system that has proven so effective for over two decades. While it may reduce costs in some of these cases, it may cause significant costs elsewhere.”⁵⁶

An aggressive defender of its perceived turf, in 1993 VAHHA pressed the state to hold CON revocation hearings against PNS. During a two-year period in the early 1990s, the Vermont Assembly of Home Health Agencies spent approximately \$100,000 on attorneys’ fees in connection with its opposition to CON applications from proprietary agencies.⁵⁷ (See sidebars on VNA and PNS.)

It is hard to see how Vermonters can accept the rationale that not having a choice of home health providers is good for their health and well being, and the best way to manage and spend health care dollars.

In a statewide survey conducted in 2001, long-term care consumers stated they were satisfied with the quality of services provided, but far less satisfied with the amount of choice and control they had when planning their long-term care services. Only 71.7 percent of consumers rated the amount of choice and control they had as “excellent” or “good.”⁵⁸

A mother of a home health client, so afraid of retaliation that she insisted on anonymity, said she gets particularly upset when VNA nurse administrators tell her that her child “has to make a sacrifice this morning, since we don’t have the staff.” Her child, she points out, has already sacrificed the use of all four limbs. “I want to stress that there definitely needs to be public information and education about the lack of choice among home health agencies. People need to be more aware about it, other than just by bumping into someone in an aisle in a store,” she adds. “I see this segment of our population growing. They realize they can have a life. In the past they gave up and thought ‘I can’t get out.’ But not anymore, and the issue needs to be publicized.”

The era of consumer choice is upon us. Once only a fantasy, consumers can, due to deregulation, choose from an array of long distance telephone services. No longer prisoners of the banking industry’s 9 a.m. to 3 p.m. hours, consumers can bank online or at an ATM, 24 hours a day. In 1997, with Congress’ approval of Medical Savings Accounts, health care consumers were significantly empowered to choose treatments in their best interest. The 2003 Medicare reform bill dramatically expanded this option, now called Health Savings Accounts.

Discussing choice, Agency of Human Services administrator David Yacovone makes the distinction between any willing provider and preferred provider. “In rural transportation, home health, substance abuse and mental health, we have a preferred provider situation. However, in some instances, we have safeguards in place, so when a closed shop doesn’t work, people can have choices.”

Yacovone points to “safety valve” language in the state budget which states that, consumers of rural transportation may seek services outside of the approved network, “for due cause.” The same idea is true for those receiving substance abuse services, where language in the state budget act permits consumers to go outside the preferred provider network for services, if waiting lists or other issues have kept them from receiving services.

Even within home care, safety valve language has appeared. Buried in the Medicaid 1915 waiver regulations is a phrase referring to choice. In the section that specifies that workers “shall

CON and Home Health Care in Other States

Eighteen states still require a Certificate of Need for home health care providers. The states use differing criteria.

Hawaii requires a CON only if the project costs more than \$1 million.

Nine states (AR, AL, TN, MD, WV, GA, NC, SC) require that the service region meet a population threshold. For instance, in Arkansas a service region with a population less than 30,000 can not have more than two home health agencies. Tennessee and Alabama use the over-65 population. Each of Tennessee’s 95 counties has between seven and 40 home health care agencies operating. In North Carolina, the documentation of 250 individuals who have gone unserved in a given country will cause the state to qualify new agencies.

All states that require a CON for home health care require providers to serve a percentage of the indigent or persons with access problems. Only North Carolina issues penalties for failure to provide such care. In Alabama, if an agency fails to adequately serve the indigent, the market is opened to new providers.

Three states (MS, KY, and NY) currently have a moratorium on CONs for home health care.

be employed and supervised by an agency which has been authorized to provide personal care services; a participant who is approved to manage her/his own services; or, a participant's surrogate who is approved to manage the participant's services.

"In addition, other agencies or organizations may be approved by the Commissioner of the Department of Aging and Disabilities to provide personal care services if and when a demand for services from additional provider agencies becomes apparent. State resources are adequate to assure appropriate monitoring of these services, and providers meet the qualifications, standards and criteria established by the Department of Aging and Disabilities."⁵⁹ No provider has applied to use this provision as of this date.

Rather than wait for BISHCA to allow new models of home health care in Vermont or for DAD to qualify more providers, Scott Goyette has decided to turn toward technology for what he needs. "I know the best way to deal with personal assistance is not to need it. The current system lacks dignity. There's not a lot of confidentiality. On the toilet you are told to hurry up and get done. I was left feeling guilty, like I was a burden. Am I a person or a pet?"

"I am learning to drive. I am having a lift installed with a ceiling track system to get me from the bed to the shower and toilet," Goyette said. "I am just trying to live my life, and my physical needs are just part of it. I don't want to be perceived as ungrateful, it's just ultimately, it doesn't serve me."

Recommendations For Change

The goal of home health care policy ought to be expanding choices among more qualified providers for independent consumers with the knowledge to exercise sound choices about their care. To that end:

1. State regulators (BISHCA) should allow home health care eligible consumers to contract with independent registered nurses for Medicaid and Medicare reimbursed services. Nurses would become participating providers in the Medicaid program like doctors and dentists in private practice. They would bill Medicaid as independent contractors, as is done for Johnny Doe's nursing care described on page 5 of this report. The home health agencies would have responsibility for determining consumer eligibility.

2. The legislature should repeal the CON requirement for home health care, and replace it with provider screening and licensing, with conditions regarding charity care. This will allow new providers to serve Medicaid and Medicare consumers, who are currently limited to VNA only.

3. The legislature should give BISHCA the authority and the resources to license small home health care and personal care agencies, perhaps using Maine's dual license model, or partial service licenses.

4. State regulators (BISHCA) should identify and contract with a private, nonprofit entity (such as the Joint Commission on Accreditation of Healthcare Organizations) to survey and accredit small home health agencies offering three or fewer services (nursing, aide and social work, for example). They should seek a similar independent, private accreditation entity to inspect and accredit personal care agencies.

5. The State (PATH) should continue to fund the assistive technology portion of Medicaid waivers, with an emphasis on providing technology first to consumers who, with certain equipment, will become less dependent on home health services.

6. The State (AHS) should codify in regulations that hospital discharge planners shall inform departing patients of the available choices for home health providers.

7. The Governor should require all relevant state agencies (such as DAD and PATH) to post information on home health and home care providers on their websites, and inform the public of the availability of such consumer friendly information, including the OASIS website.

Notes and References

- 1 Telephone interview August 25, 2003
- 2 Porter, Michael et al, "Making Competition in Health Care Work," *Harvard Business Review*, July/Aug. 1994, page 131.
- 3 Kevin O'Riordan, Sterling Services, September 24, 2003
- 4 Memo to Barbara Davis from John Dick, PATH, June 17, 2003
- 5 Anonymous source within Agency of Human Services, familiar with the cases
- 6 Medicaid Policy, Bulletin 98-11F, M710.4 (3) conditions of coverage, April 1, 1999
- 7 BISHCA website, CON guidelines, March 1999
- 8 Testimony of the Vermont Assembly of Home Health Agencies on the certificate of need guidelines, BISHCA, May 2002
- 9 American Health Planning Association for the Maryland Healthcare Commission, (AHCA-MD) "An Analysis and Evaluation of the CON Program", June 2000, page 103
- 10 Cimasi, Robert J., Academy of Health Services Research and Health Policy, 2002 annual meeting
- 11 Telephone interview August 13, 2003
- 12 AHPA-MD Survey, June 2000, Table A1, CON Regulation: Home Health Services
- 13 Linton, JD, Leslie S., "An Examination of the Vermont Health Care Policy Permitting Only the Current Network of Non-profit Home Health Agencies to Serve Medicare/Medicaid Patients", Harvard School of Public Health, March 7, 1995
- 14 Ibid., page 105
- 15 Ibid., page 28
- 16 Cimasi, op.cit., n.11, at 7
- 17 Stanley Lane, HCA analyst, BISHCA, email July 3, 2003.
- 18 Telephone interview August 5, 2003
- 19 Telephone interview August 22, 2003
- 20 www.medicare.gov/HHCompare/home.asp
- 21 Telephone interview August 25, 2003
- 22 Telephone interview August 25, 2003
- 23 Survey documents obtained from Licensing and Protection for Orleans Essex VNA, Bennington Area Home Health, Addison County Home Health, Franklin County Home Health, Town of Dorset Nursing Association, Rutland Area Visiting Nurses, VNA of VT and NH, Southern Vermont Home Health
- 24 Statement of Deficiencies and Plan of Correction, Dept. of Health and Human Services, VNA of VT & NH, G. 108 484.10(C)(i) & (ii), Sept. 25, 2002
- 25 BISHCA website, CON guidelines
- 26 Ibid.
- 27 Vermont Home Health System Report, BISHCA, September 5, 2000.
- 28 VAHHA testimony, May 2002
- 29 Telephone interview with Donna Jerry, BISHCA analyst, July 3, 2003
- 30 September 26, 2003, telephone interview

- 31 Telephone interview, September 24, 2003
- 32 Brian Trudo, telephone interview, September 26, 2003
- 33 Cimasi, op.cit., n.11, at 7
- 34 Letter to BISHCA from M.C. Salottolo, June 5, 2003
- 35 Mt. Ascutney Hospital Budget Presentation, August 2003, page 16
- 36 Telephone interview with Mary Dufort, health services supervisor, state of Maine, August 19, 2003
- 37 Letter to Tracy Chellis, PNS; from Merle T. Edwards-Orr, PhD, LICSW, FAHC, August 12, 2003
- 38 Isley, *ibid.*
- 39 Telephone interview October 3, 2003
- 40 Telephone interview, September 9, 2003
- 41 Telephone interview, September 23, 2003
- 42 Letter to Kathy McQueen from Stan Lane, health policy analyst, BISHCA, May 12, 1997
- 43 Letter to BISHCA from Kathy McQueen, October 18, 1999
- 44 Letter to PNS from BISHCA Commissioner John Crowley, May 14, 2003
- 45 Doherty, Peter, *Journal of the James Madison Institute*, Winter 2001, pages 10, 15
- 46 BISHCA, August 26, 2003, Michael Davis
- 47 www.guidestar.org
- 48 FY2001, IRS 990
- 49 IRS 990s for 2001; telephone conversation September 29, 2003 with Sid Rockliss, CFO, VNA of Chittenden and Grand Isle counties
- 50 AHPA-MD Report, June 2003, page 4
- 51 *Ibid.*, page 6
- 52 *Ibid.*, page 4
- 53 AHPA-MD Report, June 2003, page 28
- 54 Linton op.cit., n.17, page 4
- 55 Interagency High Tech Discussion Meeting Agenda, BISHCA, March 18, 2003
- 56 “The Medicaid High Tech Program”, VAHHA, February 21, 2003
- 57 Linton op.cit.n.17, page 11
- 58 Executive Summary, “Survey of Vermonters Who Use Long-Term Care, Programs and Services”, ORC Macro International, Burlington, VT, for DAD, March 19, 2001
- 59 DAD Home Based Medicaid Waiver Manual, Section H., 3. Personal Care Services, D. Provider Qualifications, January 2003

Additional References

Dale, Stacy et al, “The Effects of Cash and Counseling on Personal Care Services and Medicaid Costs in Arkansas”, *Health Affairs*, W3-566, November 19, 2003.

Kenney, Genevieve and Marilyn Moon, “Reining in the Growth in Home Health Services Under Medicare”, The Urban Institute, May 1997.

Kittower, Diane, “Kansas: Elder Care”, *Governing*, May 1997.

Vermont, Department of BISHCA, “Docket No. 03-033-H: Application of Professional Nurses Service, Inc. to offer Licensed Nursing Assistants to the Medicaid High Tech Program” (staff memorandum), October 28, 2003.