

**VAHHA Board of Directors □ Manual
Summer 2008**

10 Main Street, Montpelier, Vermont 055602

VAHHA Board Manual Summer, 2008

INTRODUCTION

The Vermont Assembly of Home Health Agencies (VAHHA), which represents all 11 not-for-profit Medicare-certified Home Health and Visiting Nurse Associations in Vermont, has prepared this home care orientation booklet for you. The information here should give you a better understanding of home care and VAHHA. If you have any questions, please call 229-0579. Also, check out our homepage at: www.vnavt.com.

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What is VAHHA?

The Vermont Assembly of Home Health Agencies, Inc. is the professional association representing the 11 Medicare-certified/not-for-profit Home Health Agencies in Vermont. VAHHA is supported through membership dues and is incorporated as a not-for-profit, voluntary private organization to offer educational opportunities and technical assistance to the member home health agencies and Visiting Nurse Associations.

The VAHHA members have also set up two separate corporations, the Vermont Home and Community Care, which was established to provide public policy advocacy for the member agencies and VNA Health Systems of Vermont. VNAHSVT is a member-owned network formed to improve community health in Vermont and to respond to changes in the health care environment. VNAHSVT provides state agencies, managed care organizations and insurers with a single contact point for statewide home health services.

VAHHA has the following goals:

- a. To increase knowledge of and to develop, improve, and expand the quality of community health services throughout the State of Vermont.
- b. To provide media for the interchange of ideas and dissemination of material relative to home health needs.
- c. To foster closer cooperation among agencies and individuals providing home health care.
- d. To foster closer cooperation between home health agencies and other health care institutions and programs.
- e. To conduct and participate in the educational programs and activities concerning home health and related community health services.
- f. To represent home health agency concerns with agencies and institutions involved with financing and surveying home health agency services.

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VAHHA Member Agencies

Addison County Home Health & Hospice

Box 754
Middlebury, VT 05753
802-388-7259

Caledonia Home Health Care & Hospice

Sherman Drive, Box 383
St. Johnsbury, VT 05819
802-748-8116

Central Vermont Home Health & Hospice

600 Granger Road
Barre, VT 05641
802-223-1878

Franklin County Home Health

3 Home Health Circle
St. Albans, VT 05478
802-527-7531

Lamoille Home Health & Hospice

54 Farr Avenue
Morrisville, VT 05661
802-888-4651

Manchester Health Services

P.O. Box 1224
Manchester Center, VT 05255
802-362-2126

Orleans, Essex VNA & Hospice

46 Lakemont Road
Newport, VT 05855
802-334-5213

Rutland Area Visiting Nurse Association & Hospice

P.O. Box 787
Rutland, VT 05701
802-775-0568

Visiting Nurse Association and Hospice of Vermont and New Hampshire

46 South Main Street
White River Jct., VT 05001
802-295-2604

Visiting Nurse Assoc. & Hospice of Southwestern VT Health Center

160 Benmont Ave., Suite 17
Bennington, VT 05201
802-442-5502

Visiting Nurse Association of Chittenden, Grand Isle Counties

1110 Prim Road, Suite 1
Colchester, VT 05446

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Characteristics of the Voluntary, Not-for-profit System of Home Health Agencies in Vermont

The not-for-profit home health care delivery system in Vermont provides all Vermonters with universal access to a full range of high quality, low cost home health services. All 11 agencies provide needed service to anyone, regardless of ability to pay or the location of his/her home. All 11 agencies have sliding scale fee schedules so that Vermonters pay only what they can afford. Also, another important feature of the not-for-profit system is the effort to coordinate and collaborate in the organization and delivery of services, rather than compete for patients, territory and funding.

The 11 home health agencies in Vermont are committed to:

- universal access to medically necessary, cost-effective, home health services throughout the state;
- local community governance, involvement and accountability;
- promotion of client self-determination and independence;
- high standards of quality performance and continuous quality improvement.

Universal Access

- no financial barriers to medically necessary services;
- no geographic barriers;
- service 24-hours/day, 7-days/week, 365 days/year;
- lowest costs and charges per visit in the nation.

Community Governance

- local voluntary boards of directors; broad based representation;
- support and commitment from towns, United Ways and local contributors;
- use of volunteers;
- accountability through governance to:
 - assess community needs & gaps;
 - oversee quality standards;
 - oversee cost containment.

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Responsibilities of the Board of Directors

The board's major duties are to:

- Manage the business and properties of the corporation or association.
- Adopt and review rules that govern the operating procedures of the board in accordance with generally accepted principles.
- Make final decisions on overall policies that govern the scope and content of agency programs and that enable the agency to reach its goals.
- Approve sound personnel policies, and see that they are current with standard good practice.
- Select, employ and evaluate an executive who is competent to direct the agency toward its goals.
- Establish, approve, and control the agency budget and financial plan; see that adequate funds are provided from all possible sources.
- Help develop community understanding of the agency's work and promote sound agency-community relationships.
- Represent the agency in community affairs and take part in the solution of community problems related to the agency's work.
- Contribute the talents of individual board members to help with specific volunteer jobs.

10 Signs of a Highly Effective Board of Directors

- Expects and encourages a diversity of opinion.
- Focuses on issues not personalities.
- Runs efficient, productive meetings.
- Understands fiscal issues.
- Works as a team.
- Recognizes accomplishments.
- Thinks in terms of systems not programs.
- Evaluates itself for greater improvement.
- Looks for opportunities and seizes them.
- Sees the future while safely grounded in reality.

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Home Care Quality Checklist

Below is a checklist of important questions concerning your home care agency.

- Does the agency supply literature explaining its services, eligibility requirements, fees, and funding sources? The agency should furnish a detailed "Patient Bill of Rights" that outlines the rights and responsibilities of the providers, patients, and caregivers alike.
- How does the agency select and train its employees? Does it protect its workers with written personnel policies, benefits packages, and malpractice insurance?
- Are nurses or therapists required to evaluate the patient's home care needs? If so, what does this entail? Do they consult the patient's physicians and family members?
- Does the agency include the patient and his or her family members in developing the plan of care? Are they involved in making care plan changes? Is the patient's course of treatment documented, detailing the specific tasks to be carried out by each professional caregiver? Does the patient and his or her family receive a copy of this plan, and do the caregivers update it as changes occur? Does this provider take time to educate family members on the care being administered to the patient?
- Does the agency assign supervisors to oversee the quality of care patients are receiving in their homes? If so, how often do these individuals make visits? Who can the patient and his or her family members call with questions or complaints? How does the agency follow up on and resolve problems?
- What are the financial procedures of this agency? Does the agency furnish written statements explaining all of the costs and payment plan options associated with home care?
- What procedures does this provider have in place to handle emergencies? Are its caregivers available 24 hours a day, seven days a week?
- How does this agency ensure patient confidentiality?

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Home Care

What is Home Care? It is health care and related services provided in the home. Services include nursing; home health aide; physical, speech and occupational therapy; medical social services; hospice; maternal child health; and other related services such as homemaking, nutrition counseling, medical supplies and equipment, transportation, and laboratory services.

Who Provides Home Care? There are 11 Medicare-certified Visiting Nurse Associations/Home Health Agencies in Vermont.

Who Receives Home Care? More than 20,000 Vermonters are served each year, with over 1 million home care visits. Home care service is provided to all who need it regardless of their ability to pay.

Some examples of those served include:

- A patient, just out of the hospital, who is improving but not fully recovered.
- A child with serious health needs who, without home care, would live in a hospital or nursing home.
- An elderly person with a terminal illness who wants to die at home.
- A child born with a condition needing regular monitoring.
- A frail elderly person not able to do shopping or light housework.
- A patient in need of dressing changes and emotional support.

Why Home Care? For many, home care offers an appropriate and cost effective alternative to care in a hospital or nursing home.

The goal of home care is to help people get well, stay well and remain independent -- at home.

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Home Care Services/Programs

Nursing: Registered Nurses provide nursing care including counseling, physical assessments and administration of prescribed treatments such as drug therapy, parenteral feeding, blood drawings for lab work, and diagnostic testing.

Homemaker Services: Trained homemakers offer light housekeeping, grocery shopping, errands, laundry, and simple personal care.

Home Health Aide: Aides provide personal care and certain treatments, as directed by the professional staff. Some examples are bed baths, changing simple dressings, and helping with prescribed exercises.

Speech Therapy: Speech language pathologists evaluate and treat language disorders and assist families with communication skills.

Physical Therapy: Registered physical therapists offer treatments to renew or increase movement and independence, to restore function and to maintain maximum performance.

Occupational Therapy: Occupational therapists evaluate a person's ability to perform simple activities of daily living such as dressing and cooking, and develop a program which helps the patient increase independent performance.

Medical Social Work: Social workers provide counseling to families and individuals to help them cope with problems associated with the care of an ill person, and assist in coordinating home care with other community programs.

High Tech: Home health agencies specialize in serving technology-dependent children and adults. High tech services include pulmonary care and infusion therapy (parenteral and enteral feeding, IV chemotherapy and IV antibiotics).

Private Duty: Nurses, aides, and attendants provide private duty care on a fee-for-service basis in the home, hospital or extended care facility. Services include homemaking assistance, shopping, errands, and companionship

Health Promotion: Preventing illness and detecting it early are key components of home care. Each year, the agencies provide thousands of flu vaccinations and blood pressure, blood glucose, cholesterol, and body fat screenings. The agencies also offer classes on nutrition, smoking cessation, heart disease risk factors, and other topics of interest.

Home Care Attendant: Clients who are eligible for the Medicaid Waiver Program can receive extended hours (up to 30 hours per week) of home care attendant services to help with simple personal care, housekeeping and meal preparation.

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Hospice: A specially coordinated home-based program that helps children and adults with a terminal illness, along with their families, cope with death by living life to the fullest. The interdisciplinary team emphasizes care directed toward expert pain and symptom control, maximizing independence and socialization and providing support. Hospice services include:

- care for the terminally ill
- respite care
- volunteer services
- bereavement services
- team of medical director, nurse, social worker, licensed nursing assistant, clergy, volunteers, volunteer coordinator

Maternal Child Health: Comprehensive prevention/early intervention services to provide medical, educational and psychosocial support for families.

Psychiatric Nursing: Psychiatric nurses provide comprehensive nursing care to home-bound clients with mental health needs.

Other Programs: In addition to the traditional health care services, many agencies offer important support services such as adult day care, blood pressure clinics, respite care, vision and hearing testing, flu clinics, glaucoma and diabetic screening, chore services, and foster grandparent programs.

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Required Guidelines for Home Health Agencies

All certified home health agencies must meet the Medicare Conditions of Participation in order to serve Medicare and Medicaid clients. These rules provide standards that define home health services, qualifications of personnel, and areas of required policy development.

Using the Conditions of Participation as a guide, home health agencies develop administrative policies and procedures that are tailored to their own agencies. Specific policies are required to address the areas of services provided, the qualifications and functions of the agency administrator, personnel policies, contract personnel, financial management, advisory committee, acceptance of patients, plan of treatment, medical supervision, utilization review and quality improvement, clinical records, and overall evaluation of the agency.

Some examples include:

- All home health services are provided under the supervision and direction of a physician or registered nurse.
- Every client must have a plan of treatment that is signed by a physician and developed in consultation with agency staff.
- All services must support the objectives outlined in the plan of treatment.
- The physician and agency staff must review and recertify the plan of treatment at least every 60 days.
- Agency professional staff must promptly alert the physician of any changes that might require an alteration in the plan of treatment.

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What Medicare Covers

Medicare pays for the full cost of medically necessary home health care including: Nursing, Home Health Aide, Medical Social Work, Occupational, Speech and Physical Therapies, home-based Psychiatric Nurse Services and medical supplies.

General Requirements for Home Health Care

Medicare Part A pays the entire cost of all medically necessary home health visits for those 65+ or disabled if:

1. The care needed includes part-time skilled (intermittent) nursing care, physical therapy or speech therapy;
2. The patient is essentially homebound (see below);
3. The doctor determines the need for home health care, orders services needed, and sets up a home health plan of care;
4. The home health agency providing services is participating in Medicare;
5. The Patients' clinical needs can be met in their homes; and
6. Patients must either be able to care for themselves or have a paid or voluntary caregiver available to meet their needs in between visits from professional staff.

Part Time/Intermittent Care

Part-time or intermittent Skilled Nursing Care means skilled care that is either provided or needed on fewer than seven days each week or less than eight hours of each day for periods of 21 days or fewer (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

Homebound

The homebound patient is unable to leave home without great effort. When she/he does, it is rare and only for a short period or done in order to receive medical care. The Medicare home care rules guidebook says: "The conditions of these patients should be such that there exists a normal inability to leave home and consequently, leaving their home would require a considerable and taxing effort". A patient is homebound if he/she is unable to leave the home without:

1. supportive devices (walker, cane, crutches, wheelchair); or
2. use of special transportation; or
3. the assistance of another person; or
4. if the patient's condition dictates that leaving the home is medically contraindicated.

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Additionally, for psychiatric patients, even with no physical limitation, the patient is considered homebound if the illness is manifested by a refusal to leave home or if it would be unsafe for the patient to leave the home.

The patient is also considered homebound under Medicare if his/her absence from the home is for dialysis, chemotherapy, radiation or other medical treatment. The patient may also attend an adult day care and may leave home to attend church or other religious service. The patient may go to outpatient therapy if in-home therapy is not available.

Psychiatric Nurse Services

Psychiatric Nurse Services in the home are covered when all the criteria for eligibility for Home Health coverage are met, and the services ordered are "reasonable and necessary for the treatment of the patient's condition and require the skills of a psychiatrically trained nurse."

Therapies

If on-going physical, occupational, or speech therapy visits are to be made, the patient must have "restorative potential". If a restorative program is not appropriate, Medicare may cover an evaluation visit, visits to manage the care plan and visits to develop a maintenance program. In addition, Medicare B pays 80 percent of the approved cost of "durable approved" equipment such as wheel chairs, in-home hospital beds and so on.

Plan of Care

There must be a plan of care established and certified by a qualifying physician that contains specificity of orders and a signature of a qualified physician. Also, the plan must be reviewed at least every 60 days. If any services are provided based on a physician's verbal order, the orders must be put in writing, and be signed and dated with the date of receipt by the RN or qualified therapist responsible for furnishing or supervising the ordered services.

Home Health Services Not Covered by Medicare:

- 24-hour-a-day nursing care at home
- Drugs and biologicals
- Meals delivered to your home
- Homemaker services
- Blood transfusions
- More than eight hours per day of combined nursing/aide
- Non-skilled nursing services

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Hospice Care (Medicare/Medicaid)

A Hospice is a public agency or private organization that is primarily engaged in providing pain relief (palliative care), respite care, symptom management, and supportive services to terminally ill people and their families.

Hospice care is a special type of care for people who are terminally ill. It includes both home care and inpatient care, when needed, and a variety of services not otherwise covered under Medicare. Under the Medicare hospice benefit, Medicare pays for services every day and also permits a hospice to provide appropriate custodial care, including home-maker services and counseling. Medicare Hospice also covers necessary medications and durable medical equipment.

Who is Eligible?

Medicare/Medicaid coverage for hospice is available only if:

- The patient is eligible for Medicare Part A or Vermont Medicaid.
- The patient's doctor and Hospice Medical Director certify the patient is terminally ill with a life expectancy of six months or less.
- No further aggressive or cure-oriented treatment is desired or recommended.
- The patient and family understand hospice philosophy and the patient signs a statement choosing hospice care instead of standard Medicare or Medicaid benefits.

Hospice Covered Services

- Nursing services
- Physician services
- Medication necessary for pain control and symptom management
- Medical Social Services
- Trained volunteers to provide respite, family assistance and support
- Home health aide and homemaker
- Medical supplies and appliances
- Short-term inpatient care of pain control and symptom management
- Respite care for up to five days to give temporary relief.
- Counseling for patients and family
- Physical, Occupational and Speech Therapy

Hospice Benefits Periods

The Medicare benefit is fairly complicated and is divided into several benefit periods. At the beginning of each benefit period, the physician must certify that the patient has a prognosis of six month or less to live. The benefit periods may be used consecutively or at intervals.

Hospice Private Insurance

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Most private insurance plans also include a hospice benefit. The rules for eligibility and the benefits offered differ for each plan.

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Act - 57 State's Rules for Home Care Agencies

1. Board composition must be 51% home care consumers (includes family members):

“(c) On or before January 1, 2008, the board of each not-for-profit designated home health agency shall be representative of the demographic makeup of the area or areas served by the agency or by the health care facility governed by the board. A majority of the members of the board shall be composed of individuals who have received or currently are receiving services from the agency or from the health care facility governed by the board and family members of individuals who have received or currently are receiving such services. The board president shall survey board members annually and certify to the commissioner that the composition of the board meets the requirements of this subsection. The composition of the board shall also be confirmed by the agency’s annual independent audit. The board shall have overall responsibility and control of the planning and operation of the home health agency, including development of the local community services plan.”

"Family member" means an individual who is related to a person by blood, marriage, civil union, or adoption, or who considers himself or herself to be family based upon bonds of affection, and who currently shares a household with such a person or has, in the past, shared a household with that person. For purposes of this definition, the phrase "bonds of affection" means enduring ties that do not depend on the existence of an economic relationship.”

2. Home Care Agency Service Plans:

“Upon initial designation or redesignation under this subchapter, each designated home health agency shall prepare for the commissioner’s approval a local community services plan, describing the need for home health services within the agency’s geographic service area and the methods by which the agency will provide those services. The plan shall include a schedule for the anticipated provision of new or additional services for the next four years and shall specify the resources which are needed by and available to the agency to implement the plan. The plan shall reflect public input from the residents of the agency’s geographic service area.”

3. Redesignation - Agencies must seek redesignation every four years.

“Agencies seeking redesignation to continue providing home health services shall file an application for redesignation in a form and manner prescribed by the commissioner.”

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4. Complaint Process - Agency complaint program must be approved by DAIL. Program must include process for consumers and staff complaints.

“The commissioner shall establish by rule standards and procedures ensuring that each designated home health agency has in place sufficient minimum grievance procedures allowing recipients of home health services, their family members, and employees of a home health agency to file complaints about access to or the cost or quality of home health services, or about other matters related to the operations of the home health agency. In addition, the rules shall ensure that the department of aging and independent living establishes and maintains an external complaint process for clients, their family members, and employees of a home health agency, including a toll-free telephone line dedicated to receiving consumer complaints.”

5. Standards - Work with DAIL to develop quality standards (see list below).
6. Shared Services – Shared service contract between the VAHHA members must be approved by the Commissioner of DAIL (see list below).

“In order to further the state’s goals of facilitating universal access to a full range of quality home health services at the lowest practicable cost throughout the state, the home health agencies are authorized and encouraged by the general assembly to enter into and perform ...cooperative arrangements among two or more agencies.”

“The commissioner shall actively scrutinize the terms or the proposed agreement and consider all relevant facts and circumstances surrounding the agreement.”

7. Designation of Geographic service areas.

“The commissioner shall specify by rule standards and procedures for home health agency designation, redesignation, and designation revocation. The designation shall provide each designated agency a franchise to provide home health services within one or more geographic service areas within which it shall have the obligation and responsibility of providing home health services for four years, except as provided in subsection (d) of this section. No home health agency shall render home health services to patients residing in a designated service area without being designated by the commissioner to serve patients in that service area.

(f) In reviewing applications from agencies seeking to expand or reduce the offering of home health services, the commissioner shall determine whether the application is consistent with the health resource allocation plan established under section 9405 of Title 18. In addition, the commissioner shall use the data collected under subsection 6305(b) of this title when reviewing any applications for additional home health agencies to operate in any area of the state.

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(g) The commissioner shall adopt by rule standards and procedures for designation revocation. In particular, an agency's designation shall be revoked if:

- (1) the local community services plan is inadequate to meet the needs of the area served by the home health agency;
- (2) the agency, for reasons other than the lack of resources, has failed or refused to implement an otherwise adequate local community services plan; or
- (3) the agency has failed to meet the performance standards adopted under this subchapter, has been given written notice of the performance deficiency, and has failed to remediate the deficiency within the time specified in the notice.

(h) Nothing in this subchapter shall be construed to prohibit collaboration among two or more such home health agencies in delivering needed services to patients pursuant to an affiliation, sharing, or other agreement under appropriate circumstances approved by the commissioner under section 6306 of this title.

8. Rules/Standards - DDAIL to develop home care standards.

DDAIL will "adopt by rule minimum program standards for the purpose of providing quality oversight of the home health agencies authorized to provide home health services." The standards will include:

- ◆ performance standards
- ◆ quality indicators
- ◆ grievance and complaint procedures
- ◆ patient safety standards
- ◆ consumer input mechanisms
- ◆ accessibility standards
- ◆ medical necessity standards,
- ◆ practices to ensure confidentiality of patient records.
- ◆ minimum program standards to ensure home health agencies do not discriminate in the provision of services based on income, funding source, geographic status, or severity of health needs and to ensure the attainment or continuance of universal access to medically necessary home health services.

9. Annual Report to Legislature:

"Annually, beginning February 1, 2007, the commissioner, as part of the department's annual report to the general assembly, shall make findings and recommendations regarding the provision of home health services in Vermont by the designated home health agencies."

"(a) the commissioner shall collect and analyze data regarding access to and the cost and quality of home health services in Vermont. Such data shall include: information on complaints, waiting lists, numbers of individuals ineligible for

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services, numbers of individuals eligible for but not provided services, numbers of patients served under and over the age of 65, total number of visits and hours provided to patients by each of the existing home health agencies; the results of patient surveys conducted by the home health agencies; data pertaining to federal and state surveys; scoring by any national accrediting organization, charitable and subsidized programs and services for uninsured or low income persons in their respective communities; copies of audited financial statements and annual cost reports; and any other quality indicators or data deemed relevant by the commissioner to monitor and evaluate access to and the cost and quality of home health services by the designated home health agencies.

(c) The commissioner shall consider the data collected under subsection (b) of this section in undertaking active, ongoing supervision to monitor performance of the designated home health agencies with respect to access, cost, and quality of home health services.

(d) If the commissioner determines that a home health agency has failed to comply with any performance standards established by the commissioner related to access, cost, or quality issues in any area of the state, or has violated a rule or provision of this subchapter, the commissioner may investigate and enforce the provisions of this subchapter pursuant to the authority and procedures conferred upon the commissioner under chapter 71 of this title as if the home health agency were a nursing home, except that the commissioner shall adopt by rule penalties specific to home health agencies.”

10. Commissioner shall approve all service agreements among the VAHHA membership

“The commissioner shall actively scrutinize the terms or the proposed agreement and consider all relevant facts and circumstances surrounding the agreement.”

1. agreements or understandings to pool or share one or more administrative functions, services, or expenses;
2. agreements or understandings to pool or share certain staffing, including skilled nursing and other personnel;
3. group purchasing arrangements designed to obtain the benefits of volume discounts and achieve other cost savings and efficiencies for the benefit of consumers;
4. agreements with managed care plans or other third-party payers, at their request and on a nonexclusive basis, to provide their members with prescribed home health services on discounted groupwide or statewide rates, terms, and conditions;
5. agreements or understandings to provide home health services, on an occasional or sporadic basis, to patients located in the designated service area of another home health agency due to special needs or other exceptional

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circumstances preventing the prompt and efficient servicing of such patients by that other home health agency or where otherwise necessary to achieve the purposes of this subchapter; and

6. agreements related to the sharing of information and technology.

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Who Pays For Home Care?

Home care is paid for by a variety of sources - individuals or their families, private and public insurance programs including Medicare and Medicaid, contributions, allocations from towns, grants and the United Way. For those who have no insurance and cannot afford to pay, all Vermont agencies offer sliding scale fee schedules so that a family need pay only what it can afford.

Medicare

Medicare is a Federal health insurance program for people 65 or older and certain disabled people. It is run by the Health Care Financing Administration. Local Social Security Administration offices take applications for Medicare and provide information about the program.

Medicare has two parts - hospital insurance and medical insurance. Hospital insurance can help pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care. Medical insurance can help pay for medically necessary doctors' services, outpatient and hospital services, and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare.

Medicaid

Medicaid is a state administered program that reimburses providers for medical care furnished to low income people. Title XIX of the Social Security Act established the program and the matching formula whereby federal grants-in-aid are made available to assist states in underwriting the costs. To be eligible for Medicaid home health services, the client must have a valid Medicaid card or other evidence showing he is entitled to Medicaid benefits. The health requirements are basically the same as Medicare although there is no homebound requirement and Medical Social Services is not a covered benefit.

There are several Medicaid programs in addition to the traditional home visiting program including:

- **1915c Medicaid Waiver:** The 1915c Home and Community Based Services Medicaid Waiver program is administered by the Department of Disabilities Aging and Independent Living. The program provides home and community based services to elders and adults with physical disabilities. Services offered are personal care services, respite, case management, adult day, assistive devices and some home modifications.
- **Medicaid High Tech:** The Medicaid High Technology Home Program is administered by the Office of Vermont Health Access (Medicaid). The program provides in-home

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application of sophisticated in-home medical technologies, medical equipment and supplies, supportive care, consultative service and case management.

- **EPSDT Personal Care Services (Early Periodic, Screening, Diagnosis and Testing):** This program provides coverage for personal care services to categorically needy and medically needed Medicaid/Dr. Dynasaur recipients under age 21.
- **Traumatic Brain Injury Program (TBI):** A short-term, community-based program geared to providing comprehensive rehabilitation services aimed at assisting the individual with community integration and return to work activities.

Commercial Insurance

All commercial or private insurance companies doing business in Vermont, such as Blue Cross/Blue Shield, Aetna, MVP, and others must offer home health benefits as part of their health insurance policy options. The number of visits, types of services and requirements for coverage vary greatly.

Private Pay

Private pay is an important part of the home health agency income. All 11 Vermont agencies offer sliding scale fee schedules so that clients pay only what they can afford.

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Vermont Medicaid

VHAP and Pharmacy Programs - The Vermont Health Access Plan (VHAP) is health insurance for uninsured adults who are not eligible for Medicaid.

VHAP Pharmacy is pharmacy and eyeglass coverage for aged or disabled individuals who are not eligible for Medicaid or VHAP who do not have pharmacy insurance.

VScript and VScript Expanded is pharmacy coverage for maintenance drugs for aged or disabled individuals who are not eligible for Medicaid, VHAP, or VHAP Pharmacy who do not have pharmacy coverage. Questions call 802-879-5900

Home Visiting - Vermont Medicaid funds all the home care services as Medicare including hospice. The rules for Vermont Medicaid home care are the same as the Medicare rules except that there is no homebound requirement.

Dr. Dynasaur - Dr. Dynasaur offers health care insurance for children under 18 and for pregnant women. The income guidelines are designed to cover as many families as possible. You may qualify even if you have other health insurance. Benefits for children include the cost of doctor visits, prescriptions, dental care, hospital care, occupational therapy, physical and speech therapy, vision care, immunizations, mental health care, and more. Benefits for pregnant women include cost of doctor visits, hospital care, lab work, tests, prescriptions including prenatal vitamins, and more. Questions call 800-250-8427

Healthy Babies, Kids and Families - Healthy Babies Kids & Families is a benefit of Medicaid and Dr. Dynasaur health insurance programs. Nurses and family support workers provide education and help to connect parents with high quality health care and support services in the community.

Family, Infant & Toddler Program - The Family, Infant & Toddler Program provides early intervention services to children aged birth to three who have developmental delays or who have conditions that may lead to developmental delays. Services include specialty clinics, care coordination services, family supports and limited financial assistance for authorized medical services. Questions call 800-660-4427.

Attendant Services Program - Consumer-Directed Personal Assistance

The Attendant Services Program (ASP) supports independent living for adult Vermonters with disabilities who need physical assistance with daily activities. What activities are covered? Attendants may only be paid to provide physical assistance with approved needs:

- Activities of Daily Living (ADLS) Include dressing, bathing, grooming, toileting, transferring, mobility, range of motion exercises, positioning and eating.
- Instrumental Activities of Daily Living Include meal preparation, medication management, care of adaptive & health equipment, management of finances and mail, shopping, and cleaning.

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Who Is Eligible?

To be eligible an individual must

- be a Vermont resident,
 - be at least 18 years old, and
 - meet all of the eligibility criteria for one of these programs:
1. General Fund Personal Services
 - have a disability;
 - need physical assistance with at least one activity of daily living or meal preparation; and
 - have Medicaid.
 2. General Fund PDAC - Participant Directed Attendant Care
 - have a permanent & severe disability;
 - need physical assistance with at least two activities of daily living; and
 - be able to direct own personal care services.
 3. Medicaid PDAC - Participant Directed Attendant Care
 - have a permanent & severe disability;
 - need physical assistance with at least two activities of daily living;
 - be able to direct own personal care services;
 - be willing to hire an attendant other than a spouse or civil union partner; and
 - have Medicaid.

How Does the Program Work?

1. After an application is received, program staff contacts the applicant to screen for eligibility. Note: Applicants who are not eligible for Medicaid PDAC will be placed on a chronological waiting list until program funds are available.
2. A program assessor completes an in-depth assessment of the applicant's needs in his or her home.
3. An Eligibility Committee (consisting of program participants) reviews the assessment and authorizes a specific number of hours of service per day. Note: The Attendant Services Program may not cover all needs and activities.

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4. The participant signs an annual agreement and enrolls one or more attendants. The participant must comply with State and Federal employment laws.
5. The participant and the attendant must complete, sign, and submit biweekly time reports to the designated payroll agent.
6. Payments are processed and checks are mailed to the attendant on an established payroll schedule.
7. Participant needs are reviewed at least annually.

Where to Apply:

Attendant Services Program
Department of Disabilities, Aging and Independent Living
Vermont Agency of Human Services
103 South Main Street
Waterbury, VT 05671-1601
Voice: (802) 241-2431
TTY: (802) 241-3557

Traumatic Brain Injury Program - The Traumatic Brain Injury Program helps people 16 years of age or older who are receiving traditional Medicaid and have recent moderate to severe brain injury requiring one-on-one instruction focusing on independent living with a goal of returning to vocational activities. Call (802) 241-2186

High Tech Home Care Services

(Katie Beckett & Disabled Children's Home Care - High Tech Program for Children)

Definition – The High Technology Home Care Program is an intensive home care program administered by the Department of Disability, Aging & Independent Living. The program coordinates medical supplies, and sophisticated medical equipment, and provides skilled nursing care for technology-dependent beneficiaries. The goal is to support the transition from hospital or other institutional care to the home or to prevent institutional placement.

Who is eligible for this program?

- A child with a disability
- The child must be under 19
- The child must need a level of care given in hospitals, nursing homes or in-patient care facilities. (For example and child with an IV or G-tube.)
- Candidates for care are beneficiaries whose care can be safely managed in a home setting with support from the health care community and a motivated family

Covered Services: When prior authorized, the program covers:

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- Supportive nursing services (RN, LPN as appropriate)
- High-Tech aide services

Guidelines

- Medicaid eligible (Please note, the parent's income and resources are not counted, only the child's income and resources are counted toward eligibility.)
- The beneficiary requires one high tech modality (i.e. respiratory equipment, dialysis, enteral parental feeding)
- A physician must document medical necessity

Program Limitations

- The following services are not reimbursable under this program:
 1. Additional nursing services requested as a result of illness or absence of caregivers
 2. Services requested to accommodate caregiver employment
 3. Services than can be safely and effectively provided by the caregiver(s)
 4. Nursing care covering 24-hours per day
- The maximum coverage of nursing care services that may be scheduled is:
 1. First day – up to 22 hours
 2. Day 2 to first post-discharge conference – up to 20 hours
 3. Beyond the first conference – hours approved by DDAIL Nursing Consultant.
- The following evidence of caregiver training must be documented in the beneficiary's care records:
 1. Successful operation of medical equipment
 2. Ability to provide therapies and medical procedures
 3. Family has capacity to provide care "24 hour rooming in period"
 4. Completion of CPR training
 5. Safety of home environment such as electrical supply

How to Apply

- Call the Health Access Member Services at 1-800-250-8427 and ask for the application for the Katie Beckett Program.

Choices for Care

The Choices for Care (CFC) program provides nursing-home level care in the home, in an enhanced residential care setting and in a nursing home.

Services Provided

- Case management
- Personal Care
- Respite or Companion Care

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- Adult Day Services
- Personal Emergency Response Systems
- Assistive Devices/Home Modification.

(24-hour care is not currently available in the home-base option.)

To be eligible an individual must:

1. Be a Vermont resident, and
2. Be 18 years of age or older, and
3. Have a functional limitation resulting from a physical condition (including stroke, dementia, traumatic brain injury, and similar conditions) or associated with aging, and
4. Meet the clinical criteria for the program (nursing home level of care), and
5. Meet all financial and non-financial criteria for VT Long-Term Care Medicaid, and
6. Choose one of three settings in which to receive approved long-term care services:
 - a. Home-Based Setting
 - b. Enhanced Residential Care Setting
 - c. Nursing Facility Setting

Individuals NOT eligible are those who:

1. Who do not meet all of the above criteria, or
2. Who have a need for services that can be adequately met with existing Medicare, Medicaid, VHAP, VA or private insurance covered services. (e.g. Home Health Agency services, Day Health & Rehab, CRT, TBI waiver, DD waiver, ASP, etc.)

For more information – Call the Department of Disabilities, Aging and Independent Living at 802-241-2400.

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Issues of Concern to VAHHA Members

Growing Number of Elderly - The growing number of elderly has major implications for home health. Each year there is a greater frequency of debilitating conditions and greater demand for extended care provided by home health agencies. The older population has been increasing at a far more rapid rate than the rest of the population. In addition, the 75-plus group is the fastest growing segment of both the Vermont and American populations. Four generation families are becoming increasingly common.

Staffing Shortages - There is a shortage of nurses, home health aides, licensed nursing assistants, homemakers, respite workers and personal care attendants, especially for the direct care workers who provide help with personal care.

Women and Aging - The elder population in Vermont, as in the entire nation, is predominantly female. Women comprise nearly 65% of Vermonters over 75, and 75% of those over 85.

Poverty and Aging - Many Vermonters face poverty for the first time after they retire. Poverty rates are high during older age partly because of substantial reductions in income and also because of the likelihood of major expenditures for health care.

Women and Children - Poverty is not only an issue for older women, but also a problem for young, single women and their children.

Transportation - Transportation to medical appointments but also for simple tasks such as grocery shopping can be a significant problem for many home care patients.

Home Maintenance - Having adequate resources to pay for home maintenance can be a serious problem. Many elderly home care patients are women, living alone in older homes, who have never dealt with home maintenance.

Aging Together - Often when a husband or wife is hospitalized the other cannot manage alone. Also, caring for a seriously ill spouse can be very difficult for some frail elderly people. And when both the husband and wife are frail and ill, the problems are compounded.

Isolation and Loneliness - Can be a serious problem for elders living alone – especially in rural areas.

Medication Management - Is an issue for many elders and mismanagement may lead to hospitalizations. Home health nurses can help but not everyone receives home care services.

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Adult Children with Mental Illness - Some frail elders are still caring for adult children with mental illness or developmental disabilities. This causes both physical and emotional strain, but their options for care are limited.

High Tech Services - A growing number of home care patients, who would have had to live in an institutional setting twenty years ago, are now able to live in their own homes.

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Frequently Used Home Health Terms and Phrases

AAA'S - Triple A refers to the five district councils on aging, previously known as the Area Agencies on Aging. Each is run independently from the other. They provide advocacy, home meals, and other services for Vermont's elderly.

Access - An individual's ability to obtain appropriate health care services. Barriers to access can be financial (insufficient monetary resources), geographic (distance to providers), organizational (lack of available providers) and sociological (e.g., discrimination, language barriers).

Accreditation - A process whereby a program of study or an institution is recognized by an external body as meeting certain predetermined standards. (See Joint Commission and CHAP.)

Activities of Daily Living (ADL) - An index or scale which measures a patient's degree of independence in bathing, dressing, toileting, eating, and moving from one place to another.

Acute Care - Medical treatment rendered to individuals whose illness or health problems are of a short-term or episodic nature. Acute care facilities are those hospitals that mainly serve persons with short-term health problems.

Case Management - The monitoring and coordination of treatment rendered to patients with specific diagnoses or requiring high-cost or extensive services.

Case-mix - A measure of the mix of cases being treated by a particular health care provider that is intended to reflect the patients' different needs for resources. Case mix is generally established by estimating the relative frequency of various types of patients seen by the provider in question during a given time period and may be measured by factors such as diagnosis, severity of illness, utilization of services, and provider characteristics.

Certificate of Need (CON) - A certificate issued by the state to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, modify a health facility, or offer a new or different health service. Such issuance recognizes that a facility or service, when available, will meet the needs of those for whom it is intended. CON is intended to control expansion of facilities and services by preventing excessive or duplicative development of facilities and services.

Choices for Care - The community-based, Medicaid waiver program. Under this program, patients who would otherwise qualify for nursing home placements, can get an expanded list of home care services beyond the traditional Medicaid services, that help them stay in their homes rather than live in an institution.

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Community Health Accreditation Program (CHAP) - Similar to JCAHO, CHAP is a national, private, not-for-profit agency which accredits home health care organizations. CHAP is a subsidiary of the National League of Nursing. CHAP establishes guidelines for the operation of home health agencies.

Case (Care) Management - A process by which providers work to improve the quality of care by analyzing and coordinating all aspects of care including social and medical concerns. Case managers are employed in the Choices for Care Program.

Case Mix - A measure of the mix of cases being treated by the provider.

Catamount Health - The state-sponsored health insurance program that is scheduled to begin on October 1, 2007. The purpose of this program is to provide insurance to those without health insurance.

Centers for Medicare and Medicaid Services (CMS) - This federal agency that oversees Medicare and Medicaid programs. Formerly known as the Health Care Financing Administration.

Certificate of Need (CON) - A certificate, issued by the Department of Banking, Insurance, Securities and Health Care Administration, to an organization to construct or modify a health facility or operation. A home care agency needs a CON to operate a Medicare-certified agency.

Cost-shift - The shift of funds - private pay, private insurance, charity, etc. - to cover program losses, usually from Medicaid-funded programs.

DDAIL - The Department Disabilities, Aging and Independent Living, the state office which administers many of the programs related to home health and community based care.

Daily Care - Medicare and Medicaid rules limit the amount of service a home health agency can provide. In order to qualify for these home care benefits a patient must be in need of "intermittent" as opposed to daily, 24-hour care. Medicare usually defines intermittent care as care needed five times a week or less.

Diagnosis Related Groups (DRGs) - Groupings of diagnostic categories drawn from the International Classification of Diseases and modified by the presence of a surgical procedure, patient age, presence or absence of significant co-morbidities or complications, and other relevant criteria. DRGs are the case-mix measure used in Medicare's prospective payment system for hospitals.

Dr. Dynasaur - The state health programs for children.

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Durable Medical Equipment - Prescribed medical equipment (e.g., wheelchair, respirator) that can be used for an extended period of time.

EPSDT (Early and Periodic Screening, Diagnosis and Treatment Program) - A federal mandate to Medicaid programs that requires all states to provide all needed services to children under age 21 who have physical or mental defects. Medicaid must provide such health care treatments and other measures to correct or ameliorate defects and chronic conditions for children who qualify.

Family Infant & Toddler Program - Provides early intervention services to children aged birth to three who have developmental delays or who have conditions that may lead to developmental delays. Services include specialty clinics, care coordination services, family supports and limited financial assistance for authorized medical services.

Fee-for-service - The health care payment system under which the provider is paid for the cost of the services provided.

FI (Fiscal Intermediary) - The agency which processes the Medicare bills for the home health agency. The current FI for all of New England is Blue Cross of Maine.

Focused Audit - One of several payment reviews by Medicare, of a home health agency. Medicare says this is not a "punitive audit" rather it is an "educational process" to help agencies discover what Medicare says the agency did wrong.

Health Maintenance Organization (HMO) - An entity with four essential attributes: (1) an organized system providing health care in a geographic area, which accepts the responsibility to provide or otherwise assure the delivery of (2) an agreed-upon set of basic and supplemental health maintenance and treatment services to (3) a voluntarily enrolled group of persons and (4) for which services the entity is reimbursed through a predetermined fixed, periodic prepayment made by, or on behalf of, each person or family unit enrolled. The payment is fixed without regard to the amounts of actual services provided to an individual enrollee. Individual practice associations involving groups or independent physicians can be included under the definition.

Healthy Babies, Kids and Families – Is a Medicaid benefit of the Dr. Dynasaur health insurance programs. Nurses and family support workers provide education and help to connect parents with high quality health care and support services in the community.

HIPAA (Health Insurance Portability and Accountability Act) - The federal law that sets the ground rules for confidentiality of patients records.

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Homebound - Medicare's homebound requirement does restrict some coverage. In order to be Medicare eligible, the law requires that a physician certify the client is confined to his/her home. (See What Medicare Covers.)

Home Health Care - Health services rendered in the home to the aged, disabled, sick or convalescent individuals who do not need institutional care. The services may be provided by a visiting nurse association (VNA), home health agency, county public health department, hospital, or other organized community group and may be specialized or comprehensive. The most common types of home health care services include nursing services; speech, physical, and occupational therapy; homemaker services; and social services.

Hospice - A program that provides palliative and supportive care for terminally ill patients and their families, either directly or on a consulting basis with the patient's physician or another community agency.

Instrumental Activities of Daily Living (IADL) - An index or scale which measures a patient's degree of independence in aspects of cognitive and social functioning including shopping, cooking, doing housework, managing money and using the telephone.

Integrated Services Network (ISN) - A network of organizations, usually including hospitals and physician groups, that provides or arranges to provide a coordinated continuum of services to a defined population and is held both clinically and fiscally accountable for the outcomes of the populations served.

Interim Payment System (IPS) - The new Medicare home care payment system that started in October 1998 and is scheduled to be replaced by the Prospective Payment System (PPS). IPS replaced the former fee-for-service system. Under IPS agencies are paid either on a per visit basis, or cost per year for their patients, whichever is less.

Joint Commission - A national, private, not-for-profit organization whose purpose is to encourage the attainment of uniformly high standards of institutional medical care. The Joint Commission establishes guidelines for the operation of hospitals and other health facilities and conducts survey and accreditation programs. Formerly known as the Joint Commission on the Accreditation of Healthcare Organizations, JCAHO. (Also see CHAP.)

Katie Beckett Children - Disabled children who qualify for home care coverage under a special provision of Medicaid, named after a girl who remained institutionalized solely to continue Medicaid coverage.

Long Term Care - A set of health care, personal care and social services required by persons who have lost, or never acquired, some degree of functional capacity (e.g., the chronically ill, aged, disabled, or retarded) in an institution or at home, on a long-term

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basis. The term is often used more narrowly to refer only to long-term institutional care, such as that provided in nursing homes, homes for the retarded, and mental hospitals. Ambulatory services, such as home health care which can also be provided on a long-term basis, are seen as alternatives to long-term institutional care.

Managed Care - The body of clinical, financial and organizational activities designed to ensure the provision of appropriate health care services in a cost-efficient manner. Managed care techniques are most often practiced by organizations and professionals that assume risk for a defined population (e.g., health maintenance organizations).

Medicaid Waiver (Home and Community Based Waiver, also known as Act 160) - The Medicaid program which provides services in addition to traditional Medicaid, so that those who would otherwise be eligible for nursing home care, can stay in their own homes. The additional services are: case management, respite, personal care services, and adult day services and the program pays for some assistive devices for patients. There is a limited number of slots available statewide for this program.

Medical Necessity - One of the eligibility requirements for Medicare home health. In order to qualify, the client must be certified that he or she has a medical necessity which requires home treatment. This rule, like the homebound rule, is often a source of considerably disagreement between the agencies and Medicare.

NAHC (National Association for Home Care) - The national trade association which represents all home care agencies - for profit, VNAs and hospital-based agencies.

OASIS (Outcomes Assessment and Information Set): An assessment tool designed to determine how people function. The added significance is that this system is serving as the data base from which PPS (Prospective Payments System) payments are determined.

Olmstead Decision - US Supreme Court decision on the Americans with Disabilities Act which mandates that states provide needed services, in the most appropriate and least restrictive environment, to those in or at risk of institutionalization. Each state is required to develop an action plan that stresses community-based.

OVHA (Office of Vermont Health Access) - Runs Vermont's Medicaid programs.

Peer Review Organization (PRO) - An organization that contracts with the Centers of Medicare and Medicaid services to investigate the quality of health care furnished to Medicare beneficiaries. The PRO for Vermont home care agencies is the Northeast Health Care Quality Foundation.

PIP (Periodic Interim Payment) - A Medicare payment system where Medicare pays an agency a set amount each month, which is a portion of the expected billings for that month. Payments are made regardless of disputes between the agency and the fiscal

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intermediary. Additional payments are made at cost settlement. The advantage of PIP is that it assures a steady flow of cash to the agency.

Prospective Payment System (PPS) - The payment system for home care which is scheduled to begin October 1, 2000, which would replace the current Interim Payment System. Under PPS, agencies are expected to get paid a single payment per person, per year.

Random Audit - The first level of audit of a home care agency by Medicare. If Medicare finds more than 10% "errors", a more intensive focused audit is likely to follow.

Respite Care - Patient care provided intermittently in the home or institution in order to provide temporary relief to the family home care giver.

Section 1915 Medicaid Waiver - Section 1915(b) waivers allow states to require Medicaid recipients to enroll in HMOs or other managed care plans in an effort to control costs. The waivers allow states to: implement a primary care case management system; require Medicaid recipients to choose from a number of competing health plans; provide additional benefits in exchange for savings resulting from recipients' use of cost-effective providers; and limit the providers from whom beneficiaries can receive non-emergency treatment. The waivers are granted for two years, with two-year renewals. Often referred to as a "freedom-of-choice waiver".

Section 1115 Medicaid Waiver - This section of the Social Security Act grants the state the ability to provide a broad range of services to Medicaid recipients that are offered in the traditional waiver program. Section 1115 waivers also allow states to change provisions on the Medicaid program including: eligibility requirements, the scope of services available, the method of reimbursement and the statewide application of the program. The Choices for Care (CFC) program is a 1115 waiver program.

Supplemental Security Income (SSI) - Program of support for low-income aged, blind and disabled persons, established under Title XVI of the Social Security Act.

Title XVIII (Medicare) - The title of the Social Security Act that contains the principal legislative authority for the Medicare program and therefore a common name for the program.

Title XIX (Medicaid) - The title of the Social Security Act that contains the principal legislative authority for the Medicaid program and therefore a common name for the program.

Vertical Integration - Organization of production whereby one business entity controls or owns all stages of the production and distribution of goods or services.

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VNAA (The Visiting Nurse Association of America) - The national trade association which represents Visiting Nurse Associations.

VNAHS - The VNA Health Systems of Vermont is a member-owned network formed to improve community health in Vermont and to respond to changes in the health care environment. The organization, which is owned by the 12 Vermont home care agencies, provides state agencies, managed care organizations and insurers with a single contact point for statewide home health services and contracting.

VPQHC (The Vermont Program for Quality in Health Care) - The not-for-profit organization charged with assuring quality in Vermont's health care system.

Wedge Audit - Similar in intent to a focused review but even more aggressive. Under a wedge audit, Medicare can review all patient charts. Supposedly, Medicare has stopped conducting wedge audits.

A Reimbursement Primer

Capitation - Under capitation, a provider is paid a uniform amount, agreed to in advance, "per capita," for each individual eligible to receive services from that provider. The provider is paid the fixed amount per person, regardless of the amount of service that each person covered actually receives. This arrangement is often referred to as "per-member per-month" or PM/PM." Capitation is becoming an increasingly popular reimbursement mechanism of HMOs. Under capitation, providers accept the risk for costs of actual services delivered that exceed the amount that they are paid and, hence have the incentive to control both utilization and cost. Since capitation involves significant financial risk for providers, great care must be taken to evaluate cost and anticipated utilization prior to accepting a capitated contract. Note that "capitation" is not the same as "cost caps" -- the two terms are often confused and used interchangeably when, in fact, their meaning is completely different.

Case-mix Reimbursement - A payment system under which reimbursements for services are set prospectively and are based on the amount or resources needed to serve the patient. The more needy the patient, the higher the reimbursement.

Cost-Based Reimbursement - An arrangement under which providers are reimbursed for the actual costs of providing services, after the services are delivered. Medicare and some Medicaid programs currently pay home care providers on a cost basis. Provider rates are based on cost reports that they submit, detailing all of their actual expenses including both direct costs and administrative (overhead) costs. Medicare also imposes cost limits or "caps" on payments (see "cost cap" below). Under cost-based reimbursement, both the cost per unit of service and number of units of service ("utilization") are variable and hence, are risk factors for the payer. Provider and payer

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incentives are opposite: providers have the incentive to maximize utilization and cost per unit of service, while payers have the incentive to control utilization and allowable costs.

Copayment - Form of cost sharing whereby an insured person pays a specified amount per unit of service.

Cost Cap - A predetermined ceiling, above which costs are not reimbursed. Providers are only reimbursed for their costs up to the cost limit; providers assume the risk for any costs above the limit. Note that "cost caps" are not the same as "capitation"-- the two terms are often confused and used interchangeably when, in fact, their meaning is completely different.

Fee-for-Service - An arrangement under which a provider charges a specific amount for a specific service. Providers develop their own fee schedules, based on their costs, market value of their services, and any other factors that providers deem relevant to their practices. Many third-party insurance and private-pay arrangements are fee-for-service. Fee-for-service arrangements are largely subject to market forces--many insurance companies will create their own schedule of "reasonable and customary" (R&C) fees and will not pay providers over those amounts; many private-pay consumers will "shop around" for the lowest fees. Many providers agree to discount fee-for-service charges based on volume.

Preferred Provider Organization (PPO) - Term applied to a variety of direct contractual relationships between hospitals, physicians, insurers, employers or third-party administrators, in which providers negotiate with group purchasers to provide health services for a defined population.

Pricing - A form of prospective payment in which specific prices for specific services are agreed to by the payer and provider, before services are delivered.

Prospective Payment - An arrangement under which the provider and payer agree on an amount that will be paid for a unit of service (such as a visit, a day, or an episode of care) before services are provided. Prospective payment is being seriously considered for the Medicare and Medicaid home health programs as a way to better plan for and control growth in these programs. Under a Prospective Payment System (PPS), the payer and the provider know in advance what the cost per unit of service will be. Hence, under a PPS, cost per unit of service is not variable and only utilization remains a risk factor for the payer. Under a PPS, both the provider and payer have the incentive to reduce the cost per unit of service.

Third Party Payers - Agency which provides direct payment to the home health agency (Medicare, Blue Cross, etc.) for services the agency provides for a client.

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Home Care in Vermont

Vermont's eleven Medicare-certified home care not-for-profit home care agencies serve more than 20,000 people a year and make more than one million home visits each year.

Home Care by the Numbers - Fiscal Year 2004

- The number of Vermonters served by the twelve home care agencies - 21,813
- The total number of home care visits made – 888,178
- Total revenues - \$91,165,968