Vermont Care Partners
Legislative Update January 19, 2016

Upcoming Advocacy Events at the State House
Vermont Care Partners is joining with other associations and advocates sponsoring ***Mental Health Advocacy Day*** on March 17th. The full spectrum of our services will be addressed including developmental disabilities and substance use disorder services. We will be looking to have a big turnout at the state house to educate and advocate for our services.

On January 27th we will support ***Community Health Day*** at the State House, an annual event held by Bi-State Primary Care. We will work with them to educate legislators about our integration efforts.

Recovery Day
February 17, 2016

Disability Awareness day
March 23, 2016

We are continuing to work with advocacy partners to develop a legislative mental health and substance abuse service caucus. Potential Topics for the caucus meetings include: funding for mental health and substance abuse services in Vermont; mental health and substance abuse as part of Vermont's health reform efforts; mental health and substance abuse services in the criminal Justice system; and children, youth and family mental health services and supports.

House Appropriations Committee Works through the Budget Adjustment Act
Vermont Care Partners is working through several issues related to the Budget Adjustment Act. Julie Tessler presented testimony on these issues as summarized below.

Group Therapy
Vermont Care Partners is concerned that the structure and rates for reimbursement of group therapy services which were recently reduced by the Department of Vermont Health Access (DVHA) are not feasible and will result in the suspension of those services. Up until July 1, 2015, we received $60 per 90 minute session for each individual with DVHA Medicaid coverage. The new DVHA Medicaid rate was reduced July 1 to $40 per session (regardless of length) and was further reduced on January 1, 2016 to $15.80 per session provided by our Masters level clinicians. If this rate reduction goes forward in January we will be compelled to eliminate some of these services as we cannot sustain further losses than we already experience. Referrals to private clinicians will not be an answer, as they too, cannot accept this low level of reimbursement.

Group therapy is considered clinical best practice to meet the needs of specific populations, and the modality is typically more cost efficient than individual services. Some of the people we have been serving in group modalities may be switched to individual therapy, but at greater cost and with lower efficacy.

Applied Behavioral Analysis (ABA)

Beginning in July 2015 DVHA secured a state plan amendment and established rates for ABA services that apply to private providers and DA/SSAs. These rates are significantly below specialized rehabilitation rates that DA/SSAs had been billing DMH for these services previously. Additionally, DVHA require several layers of prior approval and clinical review and limits which professional can bill to higher level Board Certified Behavioral Analysts (BCBA), instead of direct one-on-one behavioral technicians. Finally, there are limits on the hours that can be billed.

Because of the cost of ABA services (intensity, in-home) and the cost of employing the highly skilled BCBA, the current rates dramatically impact both the private providers and DAs' ability to provide this service beyond a minimal capacity. The programmatic structure and cost of employing BCBAs make ABA services financially risky. All the DAs are gauging their ability to provide limited amount of ABA while not creating greater fiscal challenges for their agency. Several of the DAs have children they began to serve and will continue until the service is no longer necessary and will not take on additional children.

Designated Agency Vacancy Savings (IFS)

Vermont Care Partners wants to clarify that designated agencies do not return funds to the State as vacancy savings when we have earned funds through the services provided. In the case of the vacancy savings from the Howard Center in this line item of the Budget Adjustment Act, it is appropriate for the State to recoup these funds because the Howard Center was unable to fill positions to earn the revenue as anticipated. This program was part of the Act 79 work to improve community resources to reduce the demand for inpatient care.

Vermont Care Partners is strongly committed to payment reform and has been working with state government on a number of fronts to develop and pilot payment models that can improve service quality, outcomes and cost effectiveness. So far, the two Integrated Family Services (IFS) pilots have been very successful at meeting those goals. Vermont Care Partners wants to ensure that the payment model is honored and the goals of the pilot continue to be achieved. We need to let these pilots proceed as planned and agreed to and then properly evaluate the effectiveness of the funding and service delivery model. Vermont Care Partners does not support a rescission in FY 16 funding to NCSS for the IFS program which would enable AHS to recoup deferred funds from FY 14 which are supposed to be used for innovation and to cover future financial risk as documented in correspondence and specified in a signed agreement with the State.

Margaret Joyal, the Chair of Adult Outpatient Group of Vermont Care Partners and Director of Outpatient Services at Washington County Mental Health Service testified that the rates for reimbursement for group therapy services as proposed by DVHA are not feasible and will result in the suspension of those services, an increase in waiting lists, and a further degradation of the community system.

Last year Adult Outpatient programs saw 7,000 people and sustained $1 million loss. This is in part, due to our mission to provide care regardless of ability to pay. For example, 10% of clients are uninsured with another 5-10% having high deductible insurance. As clinicians in the private sector are forced to limit/deny access due to the new DVHA Medicaid rates, waiting lists at the designated agencies will grow at the same time that we are less able to provide them.

One of the unintended consequences of going to this rate will be more service provided in individual formats at a much higher rate. For example, if we now see four clients in a group at $30.00 each and we

close the group, we will endeavor to see those same individuals at approximately $70 per session. Our billing to DVHA will go from $120 to $280.

A typical group costs approximately $ 180.00 to provide. This includes: two staff for 1.5 hours of group therapy; supervision, preparation time, and administrative support.

Randy Bulpin, a Licensed Clinical Mental Health Counselor and private clinician spoke about the cuts to the group therapy rates. He said it is an established and proven mode of working with individual with a diverse range of challenges. He works with youth with social and emotional challenges. Sometimes he uses group therapy as an adjunct to individual therapy. The new rates at $15 per session will make group therapy untenable. If you take the supports away the community, he predicts greater use of pharmaceutical inventions.

Jennifer Auletta, Clinical Services Director at Family Center of Washington County spoke about the importance and strength of group psychotherapy. They focus on parenting groups and parent child work and group work with youth. She too, expressed concerned the impact of the reduced rate on the group therapy work they are doing with parents.

Ed Paquin, Director of Disability Rights Vermont and spoke for the Coalition for Disability Rights and highlight the importance of community services. He said, we rely of the strength of the DAs, but we are making it economically impossible to provide group therapy which is sometimes court ordered. He noted that VDR is sometimes at odds with DAs because their funding does not allow them to maintain a solid base of services. These agencies who serve people with serious disabilities cannot cost shift like some other Medicaid funded agencies can.

Catherine Simonson, Chief of Client Services for Howard Center gave a presentation on ABA. The Howard Center has 12 Board Certified Behavioral Analyst on staff and has been providing this specialized services through Schools, DCF, DMH and with DVHA. The DVHA change in rates and structures has drastically reduces reimbursement. The current rate is creating a loss of $34,000 per client. As a result the Howard Center is not accepting new referrals and has frozen their program at 13 clients.

The outcomes of their program to date have been tremendous for families and children as documented with standardized tools. Often children make tremendous gains in verbal communication and can then participate in schooling without specialized supports. Catherine said that in order to continue to achieve these outcomes we need sufficient Medicaid rates and allocations.

A mother of two children who are enrolled in the program spoke about the challenges of her children had and how they learned to communicate, socialize, mange aggression and learn because of the ABA services received. Since the rates were reduced and the program restructured her children are not making the same progress and the services are not as responsive to the family's needs.

House Appropriations Takes Testimony on ABA

Ashley Berliner of DVHA believes that current access is very good. She explained the history of ABA; the money for ABA used to be in DMH before it all got moved back to DVHA (except IFS funds for NCSS) then

the dollar amount was reduced and now some of the money needs to be replaced with a budget adjustment increase to DVHA. Mental health used to pay better rates than DVHA. Selina said DVHA set the rates – they are not based on RBRVS methodology. Medicare does not cover ABA and may never cover those codes.

DMH had $3.67 million for ABA which was reduced by $1.2 million when moved to DVHA in FY 2016 DVHA is funding private providers in addition to DVHA. DVHA reviewed other states to get a sense of the necessary rates. They started at lower rate and increased after discussion with providers. The rates are still lower than the DMH rates. She acknowledged that the DVHA rates don't meet DA costs. Additionally, DVHA requires specific best practice clinical requirements.

Committee Chair Johnson asked if group therapy funding could move from DVHA to DMH. Ashley said they are looking at the issue of DMH funding moving to DVHA and if it makes sense to have two different sets of rates for the same services. When asked if DMH could pay under a different methodology, she said yes. It could also be impacted, if the funding is moved to APM bundled payment methodology.

The House Health Care Committee expressed concern about the impact of reduced ABA rates after move to DVHA, but their recommendation was not fully clear. A specifically higher rate was not requested and they seemed to imply that this was a FY 2017 issue. " As we move into consideration of the FY 2017 budget, the Committee urges the Appropriations Committee to ensure that provider rates are sufficient to meet the goal of providing more Vermont families with access to high-quality ABA services, assuming that continues to be the State's policy."

On the question of modifying and reducing group psychotherapy reimbursement rates, the Health Care Committee noted concerns about the impact on providers and the potential limitations on access to treatment in the most clinically appropriate setting, which could result in Medicaid beneficiaries receiving more costly services in less appropriate models or settings.

House Human Services Committee Works on the Budget Adjustment Act
Frank Reed, Shannon Thompson and Melissa Baily from DMH spoke about the Budget Adjustment Act. They explained that DVHA discovered the reimbursement methodology for group therapy was not in accordance with the state plan. Additionally, the rate of reimbursement was an outlier when compared to other states. Therefore, DVHA modified the methodology and reduced rates to address these two issues.

Aaron French and Ashley Berliner explained the switch to per session billing instead of the 15 minutes increments for group therapy. This brings the methodology into the RBRVS the federal standard. CMS governs RBSVS methodology for rates.

Compliance with Correct Coding Standards

- Per the National Correct Coding Initiative, the CPT code definition of group psychotherapy (90853) has a unit concept of "1 session".
- Prior to the change, DVHA was using a unit concept of "per 15 minutes".
- Vermont Medicaid was not complying with the correct unit definition. Effective 7/1/15, Medicaid allows 1 session/day for group psychotherapy codes.

Align with resource based relative value system (RBRVS) payment methodology.

- Medicaid State Plan requires that reimbursement of professional services follow RBRVS.
- RBRVS is used to set rates for professional services. It is the same underlying system used by Medicare. It set rates for nearly all medical services covered by Medicaid.
- Medicaid reimbursement for group therapy was based on a value 2Xs what would be calculated under RBRVS.

To comply, Medicaid updated the rate in 2 steps to allow for a phased in approach: 1. Effective 7/1/15 the rate for 1 session = $41.00 2. Effective 1/1/2016 the rate was updated to current RBRVS methodology = $20.50

The RBRVS fee schedule uses cost data to determine how much resources are needed to do a particular service relative to all other services.

- RVUs are set based on a formula that uses data to derive relative valuation of each individual healthcare service. The formula uses utilization, physician effort, direct and indirect cost data to derive rates. The process is transparent and governed by federal proposed and final rule making.
- Medicaid's conversion factor is based on the amount of legislatively allocated dollars available to reimburse for professional services.
- The time spent planning for a group session, arranging for services, providing reports and communicating with other health care professionals is considered part of the pre and post-service work already built into the RBRVS methodology for psychotherapy codes.
- It is maintained by CMS for use in the Medicare program and is updated annually.
- It is not preferable to pull a single service from the fee schedule for the following reasons:
- It requires a state plan amendment (SPA) and would require justification and supporting data on the need for deviation from the methods for rate setting. For example, quantifiable demonstration of an access to care issue.
- It requires procedures that deviate from standard operating procedures and are at high risk for errors in implementation or updates.
- It sets precedent for resolution of rate disputes to result in arbitrary rates not set based on recent cost and utilization data.
- The reason this rate change is necessary is due to this code being treated differently and resulting in mis-valuation of the service over many years.
- Providers were previously allowed by DVHA to bill per 15 minutes instead of per session, as required. When rate updates were done, a manual entry was needed to convert a per session rate to a per 15 minute rate. This calculation was done in error and resulted in a per 30 minutes rate.

Carey Hathaway, the CFO for DVHA explained that DVHA must follow RBRVS but DMH does not.

DVHA plans to monitor for signals of an access to care issues as a result of this change before considering alternative payment for group therapy.

- DVHA reviews any member or provider complaints regarding an access to care issues
- Review conducted by Reimbursement and Provider Member Relations Units Includes review of:
- Utilization (how many members accessed services in the last 24 months)
- Service areas - Network and provider capacity - Reimbursement for services
- Regular communication between DVHA and provider, particularly providers considering leaving network

In previous budget requests, DVHA has requested additional funding for all professional services to help alleviate the disparity between its rates and Medicare and commercial rates. Any additional funding to professional services would increase the group therapy rate proportionately to other services.

Margaret Joyal, the Director of Outpatient Services at WCMHS and Chair of VCP Outpatient Group testified that DMH Medicaid is at a higher rate, but there is a cap on DMH Medicaid. After DAs meet the cap they have to pay back money and bill DVHA for clinical codes at the fee-for-service rate.

The DVHA rate cut will double the WCMHS waiting list. Right now there is a 3-4 week wait for individual psychotherapy. Margaret explained that the DA system has a commitment to serve people whether or not they can pay. She knows that people will not have other options if we deny them clinically appropriate services.

Margaret pointed out that the accepted standard of care is 1.5 hour session, but DVHA set their rates on an hour long session. Deputy Commissioner French countered that there is no time limit on the groups.

It was estimated that WCMHS will lose $40,000 annually due to this cut. Other agencies will close down their groups. Individuals reentering the community after incarceration often have group therapy as a condition of reentry. They may end up re-incarcerated.

Margaret said our 'ask' to the State is simply to stay at the $40 per session rate, but Carey doesn't think they can just increase it. First they must show evidence of a lack of access. They will look at number of claims, including Medicaid transportation, as well as provider adequacy (number of providers serving people with Medicaid coverage).

Joint Session of House Health Care and House Appropriations Committee Considers DVHA Budget

There was a discussion about ABA. Commissioner Costantino said many states are concerned about the cost. During the discussion of group therapy he acknowledged that the providers are not happy with it, but said we are probably in the upper quadrant of New England state rates, quoting the $20 per session for MDs. Rep Mary Hooper was clear that we started at $60 per 1.5 hour session and then went to $15 per session.

House Human Services Hears about Integrated Family Services (IFS)

Agency of Human Services Secretary Hal Cohen and IFS manager Carol Maloney spoke to the House Human Services Committee about the IFS pilot in the context of the Budget Adjustment Act. They explained that they are piloting payment reform in 2 regions. The vision is to bring state government and local communities together to ensure holistic and accountable planning, support and service delivery aimed at meeting the needs of children youth and families. In FY 2013 CSAC started and in FY 2014 NCSS started. Secretary Cohen emphasized that both projects are doing fantastic and they have an excellent relationship with the DAs involved and want to expand.

He went on to explain that after the FY 2014 ½ year start up NCSS had over $595,000 and asked for a risk and/or innovation pool of deferred revenue. In June of 2015 there was additional $585,000 of unspent revenues. He noted that they might have come up short by a few cases. So in June when it came to budget adjustment, Hal felt it wasn't appropriate to not recoup funds. They met in October and discussed pulling some of those monies. It was acknowledged to the Committee that there was some

disagreement by NCSS, who saw this as earned income. Hal doesn't see it as earned and also acknowledged receiving emails from NCSS requesting clarification. However, he thinks they agreed that AHS would change the rate and pull back some of the money each month to make up for the amount of funds AHS wanted back. He told the Committee that AHS would make up for any losses, so a risk pool wasn't necessary and said they had discussed an innovation investment.

He expressed surprise that there was a legal opinion issued on the matter by Vermont Care Partners. The AHS attorney disagrees with it. The Secretary thinks it is important that we had an agreement and there was ample time to discuss this over the next couple of weeks. Hal wanted to make it clear that NCSS is sitting on $1.2 million, so the reduction in funding in FY 2016 will not impact services.

In response to questions Secretary Cohen asserted that in FY 2013 NCSS didn't provide all the services they were paid for. He said that if it was earned income, NCSS would not have had to ask to defer revenue; this is not unrestricted funds.

Todd Bauman, Director of Children's Services and Amy Putnam, Chief Financial Officer for NCSS clarified some points. NCSS served every person who called and expanded the services by 20% to reach beyond the Medicaid clients they were required to serve. Previously there had been many different eligibility requirements. Many eligibility, service and payment rules went away.

Although NCSS would have liked to give the staff raises with the excess funds the IFS plan was to reinvest funds. Using a community forum they planned on investing in residential services because over the last 3 years the region went from having 6 to having 30 kids being sent out of region and some out of state. They submitted a proposal to invest funds to bring kids back home which they think will save the state $25,000/kid with a higher quality service.

Amy reviewed how at the beginning of IFS, they took finance streams and brought them together; there was no upfront funding. She said they hit all the Medicaid beneficiary targets in FY 2014 and FY 2015. From an accounting standpoint the revenue was earned. They achieve health reform without one new dollar.

Todd explained that from NCSS's perspective, IFS is a transformative approach with a new staffing model giving more family and home based care. Unfortunately at the beginning they lost some staff who didn't like the new model. This pushed the caseload on to existing staff that had to serve more children. This year the staffing pattern is balanced so the savings are not likely to be repeated as staff costs are up a little. Plus, now they need to look at new issues like parental substance abuse. Flexible funding allowed embedding substance abuse clinicians in schools. We want to fit our investment with AHS priorities, Todd said. NCSS is currently looking at more staffing in homes and maybe a local foster home. When Committee Chair Pugh asked how they did all of this with no new money, Todd explained that at the beginning the staff worked over time, but that is not sustainable over time.

Senate Appropriations Committee Begins Budget Adjustment Analysis

DVHA Commissioner Costantino testified that mental health and substance abuse services are trending high in his budget. He gave am overview on funding for ABA. The Committee Chair Senator wanted to know how many children are being served and it ABA would reduce the cost of special education. She also asked what will be the impact of reducing the group therapy rates. The

Commissioner said DVHA is looking to see if the utilization of rates for individual therapy is going. He said DVHA is trying to set rates consistent with other New England states. He believes Vermont is now in the upper quartile of rates. Senator Kitchel responded, "You were already saving $1.8 million in the FY 2016 budget, and now you are planning to save more through the Budget Adjustment Act. It seems like a lot of impact for just a half year".

Senator Kitchel is interested in where we are at with substance abuse treatment and meeting the need. What is the impact of Medicaid reimbursement for LADCs? Commissioner Costantino said he thinks 40 LADCs have signed up and will check.

Senator Kitchel is also concerned about Medicaid spending increases in departments other than DVHA.

Department of Mental Health (DMH) Commissioner Frank Reed reviewed his Department's BAA request and fielded a few question on IFS. He acknowledged that NCSS had put forward a proposal to spend the funds and the Committee Chaired then ask why if the funds had been agreed to is it under discussion in this building?

She also questioned whether the legislature had put more resources into adult outpatient as part of Act 79. What do we have for investments in Act 79 and how did that align with what was planned? The Commissioner will present the latest Act 79 report to the Committee at a later date, but briefly noted that much of the community funds went to mobile crisis and work with law enforcement.

House Health Care and Human Services Joint Hearing on Health and Payment Reform
Judy Peterson the Director of the VNA of Chittenden and Grand Isle Counties, speaking on behalf of the VNAs of Vermont gave the foundation of her remarks with the statement that health reform cannot succeed without a strong home health system. She asked critical questions including:

- How will ACOs reduce duplication of case management and other community services?
- What will the cost of the new infrastructure be?
- What will the system do to improve Medicaid rates?

Recommendations:

- Expand Hospice services;
- Fund nursing services in between Medicare episodes of care with chronic care management and preventive nursing
- Restructure Choices for Care and improve the rates so there is an incentive to grow the program;
- Increase access to At-Risk families to nurse home visiting
- Seek waiver of restrictive Medicare rules like the rule that limits payment for visiting nursing to those who are homebound;
- Increase opportunities for in-home rehabilitation
- All-payer payments should be made on a regional basis to ensure local decision making.

The value of mental health and substance abuse in improving health and health care was described along with efforts to integrate and collaborate with other health providers.

Mary Moulton, the Director of Washington County Mental Health Services and speaking on behalf of VCP explained the importance of adding mental health into the All Payer Model. Challenges to future collaboration include: the problem of low reimbursement rates; wait lists, low compensation; and the

need for a sustainable business model. Health dollars spent on DA/SSAs will have the most impact achieving the triple aim. She said we should look at investing resources in community services to reduce the high cost medical care and this investment is needed up front. We should invest in both the ACOs and the community providers.

John Michael Hall explained that the APM model is premised with hospitals at the center of the universe where they are put in charge of controlling health care spending. 75% of Medicaid spending is not included in the All Payer Model (APM) which is focused on Medicare A and B, physician and hospital payments. We cannot leave the community based services in the fee-for-service model. We are at a cross roads, if you compartmentalize these services health reform won't work. Year after year we give increases to hospitals and nursing homes, but not to community based services, then it is no wonder that health care costs increase due to avoidable health care conditions which we treat in the most expensive settings. Mike said buy it don't build it" – we need to utilize the community-based infrastructure not have hospitals and ACOs rebuild it. Mike asked the Legislature to clarify the principles for the APM.

Patrick Flood the Executive Director of Northern Counties Health Care, an FQHC which includes a home health system. He focused on a few points:

1. There is good reason to pursue an APM waiver because the flexibility would allow us to move away from fee-for-service payments and with flexibility we could do more work with patients by phone. Flexibility in home health rules would enable more home care and reduce hospitalization.
2. We need to strengthen primary care. We are losing primary care physicians (PCPs) and it's hard to replace them. PCPs are overwhelmed with documentation and poor reimbursement.
3. If we are going to reform the system, mental health, home health and aging services are essential.

Chair of the Green Mountain Care Board Al Gobeille also testified and made the following points:

- He said that January 1, 2017 is the goal for the APM start date
- He wants to include community provider s from the start, but if we can't we'll stage in the community providers
- When asked about Mike Hall's plea "buy – don't build!" AL said, we will not build a new VNA or other organization. We need to figure out how we integrate those services. The ACO will want to direct MORE money to the community agencies because that will reduce costs."
- When House Health Care Committee Chair Lippert asked if some of the CMS rules can be waived for providers Al said,"Yes – but probably not in the first year".
- Although Al acknowledged the need to move money to the community, he believes its up to the ACO to do it.

House Health Care Committee Hears Overview of Department of Health by Commissioner Chen

In his overview of the Department of Health Dr. Chen explained that alcohol induced liver disease, opiates and suicides have led to rising death rates for middle aged white Americans and it is critical issue in Vermont. Mental health and substance abuse are one of the top three priorities for the Department of Health.

To take action or for more information, including the weekly committee schedules:

- Legislative home page: http://www.leg.state.vt.us
- Sergeant-at-Arms Office: (802) 828-2228 or (800) 322-5616
- State House fax (to reach any member): (802) 828-2424
- State House mailing address (to reach any member):

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- Email, home address and phone: Legislators' email addresses and home contacts may be found on the Legislature home page at http://www.leg.state.vt.us
- Governor Peter Shumlin (802) 828-3333 or http://governor.vermont.gov/

The purpose of the legislative update is to inform individuals who are interested in developmental, mental health and substance abuse services about legislative advocacy, policy development and activities that occur in the State Legislature. The Vermont Council is a non-profit trade association whose membership consists of 16 designated developmental and mental health agencies.

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