Vermont Care Partners

Helping people and communities live healthy, safe and satisfying lives.

Legislative Update February 9, 2016

Five Joint Public Hearings on the Governor's Proposed FY 2017 State Budget
The Vermont House and Senate Committees on Appropriations are seeking public input on the FY2017 proposed State budget and will hold five joint public hearings Monday, February 15, 2016, 6:00 – 7:00 p.m. at 5 locations across the State. For further information, please go to: http://www.leg.state.vt.us/jfo/link/CommunityBased%20Joint%20Public%20Hearings%20site%20list

The Committees will take testimony on the Governor's FY 2017 State budget proposal at that time. Anyone interested in testifying should come to one of the hearings. Time limits on testimony may apply depending on the volume of participants.

To view or print a copy of the proposed budget, go to the Department of Finance and Management's website at: http://finance.vermont.gov/state_budget/rec.

For more information about the format of these events, or to submit written testimony, call Theresa Utton-Jerman or Rebecca Buck, Joint Fiscal Office, 802-828-5767 or toll-free 1-800-322-5616; or e-mail: tutton@leg.state.vt.us or rbuck@leg.state.vt.us. Requests for interpreters should be made to the office by 3:00 p.m. on Monday, February 1, 2016.

Advocacy Events at the State House
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.

Recovery Day February 17, 2016

Disability Awareness Day March 23, 2016

Vermont Care Partners Releases White Paper on Workforce
VCP has released a white paper entitled: Vermont's Designated and Specialized Service Agency System – A Workforce at Risk. The paper concludes that due to chronic underfunding of Vermont's Designated/Specialized Service Agency system's ability to recruit and retain workforce to support Vermonters with developmental, mental health and substance abuse issues has reached its breaking point.

House Appropriations Committee Reviews the Agency of Human Services 2017 Budget Request
For AHS and Department Budget information please use this link:
http://www.leg.state.vt.us/jfo/dept_budgets_fy_2017.aspx

During the presentation of the Agency of Human Services (AHS) Budget Committee Chair Mitzi Johnson asked Secretary Hal Cohen about why we have varied approaches for payment rates. For instance, the division of rate setting has been setting increase for some providers, but not others. Secretary Cohen said they are having discussions on this topic in state government and he noted that hospitals can expect annual increases, while other Agency of Human Services providers cannot. Representative Johnson said we could reprioritize how the funds are expended. The Representatively from Secretary Cohen was that payment reform can make a difference, because it will improve focus on value of the services. AHS pilots are developing better outcomes for less funds.

It was pointed out by Representative Peter Fagan that we are asking designated agencies to provide quality services while not paying them enough to recruit and retain staff. We are slowly starving them due to lack of funding.

Presentation on Department of Mental Health Budget
The Department of Mental Health (DMH) budget was presented by Commissioner Frank Reed and members of his management team: Director of Quality Emma Harrigan, Legislative Counsel Karen Barer, Deputy Commissioner Melissa Bailey, Policy Director Nick Nichols and Finance Director Shannon Thompson.

Emma reviewed the RBA score card results which received many accolades and interest by the Committee. Melissa Baily spoke about moving from 120 to 40 outcome measures for the master grant. Representative Toll expressed growing confidence in the mental health system.

There were questions about Success Beyond Six services, specifically what are the costs and salaries paid to the workers.

Act 58 charged DMH and DVHA to develop an implementation plan to achieve financial integration of public funding for mental health services through DVHA while oversight stays in the departments of jurisdiction.

There are three topics addressed in the report as presented by the Commissioner:
1. A study of inpatient psychiatric care payments.
2. Development of financial models which work with health payment reform alignment
3. Reviewing coverage and payment policies

Task One –Inpatient Psychiatric Care Payments Activities and Timelines December 2015 –June 30, 2016
- Review and refine joint policy and clinical criteria for children's and adult services (e.g., voluntary versus involuntary stays; screening procedures; continued stay criteria; rates and payment guidelines, etc.)
- Identify decision making hierarchy and conflict resolution processes for joint oversight structure
- Determine best practices for involuntary admissions that balances : the State's obligation for payment; the client's clinical needs; and court orders
- Assess data and clinical trends to identify options for community alternatives (e.g., community assisted treatment) to inpatient admission for children's and adult services
- Identify options for a joint DMH/DVHA hospital review process
- Establish joint DMH/DVHA fiscal team to conduct further analysis.

Task Two –DMH DA/SSA Financing & All Payer Model Alignment December 1, 2015 –December 31, 2016
Alignment with the All Payer Model and exploration of new finance models to support excellence in mental health and substance abuse treatment

Establish AHS/DA/SSA/VHCIP All Payer Model Work Group to:

- Assess provider readiness and risk tolerance
- Analyze current financial methodology and program requirements
- Identify targeted services and beneficiaries
- Review options for new finance models
- Identify quality measures and reporting requirements

Workgroup outcomes:

1. Produce an implementation plan including subsequent phases of the project that would expand to additional services and providers.
2. Implement revised DA/SSA performance measures in July 1, 2016 provider master grant agreements
3. Determine if additional legislative or policy changes are needed to implement desired changes
4. Determine if new finance models and All Payer Model Alignments have stakeholder consensus and if so, finalize timelines for implementation in 2017

Task Three - Activities and Timelines December 1, 2015 – June 30, 2016

1. Review of Medicaid coverage and payment policies for similar services provided across multiple AHS programs

• Establish joint DMH/DVHA policy and operations work group

2. Determine if additional policy or funding alignments are appropriate given the findings of the review
3. Determine if policy and funding recommendations align with the All Payer Model
4. Determine if Value Based Purchasing Opportunities exist and prioritize those opportunities for design and development

• Engage Stakeholders in review and discussion of options

5. Determine if policy or legislative changes are needed to implement desired changes

• Engage Stakeholders in review and discussion of options

6. Prioritize coverage and payment policies for change in calendar year 2016 and 2017

Court Ordered Involuntary Medication

Chair of the House Human Services Committee Ann Pugh began the testimony from the Department of Mental Health with a strong statement expressing her concern that the Administration proposed a $5 million savings in the Medicaid budget based on assumed savings from changing involuntary treatment law. That would require the House Human Services Committee to make a major policy change in just 6 weeks to meet the budget cycle. She noted that they worked very hard 2 years ago to come to the current statute and that Act 79 has not even been fully implemented, yet. It was furthered noted that House Human Services would be looking at the DVHA budget to come up with the $5 million savings that will not be achieved by changing involuntary treatment statutes.

Frank explained that he was not aware of the proposal to change inpatient treatment until the Governor's speech. He is in favor of timely treatment. DMH will have a policy forum on the topic.

Representative Pugh said if not enough resources are available in AOP, perhaps we need to reallocate resources.

DMH FY 2017 Budget Request Summary:

The total increases are $494,692 gross and $751,959 GF plus some AHS net neutral funds

- Rescission Items: ($258,650) Gross ($127,708) GF
- Salary & Fringe Increase $682,602 Gross $311,399 GF FY 2016 salary and related fringe

- Retirement Incentives ($225,927) Gross ($104,461) GF Savings associated with 2 positions
- Workers Compensation Insurance ($159,416) Gross ($72,833) GF This is a reduction in expense
- VPCH Vacant Position Step Increases: $159,241 Gross $72,741 GF Psychiatric Nurse positions
- VPCH Current Nurse Step Increases: $105,759 Gross $48,311 GF VPCH nurses step increases.
- VPCH UVM Contract Increase: $314,869 Gross $143,832 GF physician expenses
- Reductions to VPCH Contracts: ($150,000) Gross ($68,520) GF for medical and therapy services
- Savings from Morrisville Rent: ($85,860) Gross ($85,860) GF Morrisville lease ended in FY 2015.
- Fee For Space Charges: $96,031 Gross $43,429 GF Fee For Space allocation.
- Internal Service Funds/Property Management Surcharge: ($25,087) Gross ($11,371) GF
- Peer Services for Young Adults $137,040 GF Wellness Coop, Another Way, Youth in Transition
- Vermont Cooperative for Practice Improvement (VCPI) $0 Gross $26,494 GF transfer $58,000 of Federal to GC Investment funds to continue funding to VCPI.
- Suicide Prevention $72,724 Gross $33,220 GF National Action Alliance on Suicide Prevention in two regions in the state and possibly expand training opportunities to other areas.
- Technical Adjustment to Federal Fund Spending Authority ($900,000) Gross
- PNMI Increase (3%) $140,953 Gross $64,387 GF 3% increase issued by rate setting.
- HUD Funding Reduction Impact – Preserve transitional housing: $90,000 Gross $41,112 GF Transitional housing for individuals at risk of or homeless at NCSS when HUD funds run out.
- Respite DOL Impact: $378,803 Gross $173,037GF DOL Fair Labor Standards Act (FLSA) rules effective October 13, 2015 must, pay at least minimum wage for all hours, including overtime. Respite (hourly or overnight)
  AHS Net Neutral
- Transfer from DCF for IFS DAP program – AHS Net Neutral: $344,600 Gross $157,413 GF Diagnostic & Assessment Program at NFI.
- Transfer from DCF for Therapeutic Child Care – AHS Net Neutral: $267,821 Gross $122,341 GF
- Success Beyond Six $3,000,000 Gross $1,370,400 Program growth for the SBS program is expected to be $3M more than FY 2016 base appropriation, bringing program total to $51.3M.
- ABA Funding for NCSS from DVHA $429,099 Gross $196,012 GF Transfer ABA funding from DVHA to DMH for NCSS bundled case rate for the IFS initiative in that pilot area.

DAIL Budget Request for Fiscal Year 2017

DAIL Commissioner Monica Hutt spoke about how our developmental services system does the right thing ethically with our focus on community services and we meets the federal requirements, too. She feels passionately, about having communities enriched by elders and people with disabilities. She noted that changes in the federal Home and Community Based rules will need to be addressed. We are making steady progress in achieving outstanding supported employment. She highlighted how cost effective our community services are compared to institutional care.

In the Commissioner's overview of developmental disabilities services she said the goal is cost-effective, integrated community living. In FY 2015, 2,917 Vermonters with developmental disabilities received home and community-based services. Other services include Flexible Family Funding, Family Managed Respite, Bridge Program: Care Coordination, Targeted Case Management, Vocational Grants and one 6-person Intermediate Care Facility. In FY 2015, 1,213 people with developmental disabilities received supported employment to work, an 8% increase over the previous year. We serve: 4,408 individuals across all programs (unduplicated).

Here are excerpts from the Commissioner's presentation:

How well we serve them:

• Our employment services have been recognized as a national model with a 27% increase in the number of people on the job over the past five year period. Vermonters served in developmental disability services are earning wages of over $4.27 million a year, reducing federal SSI payments by an estimated $1.7 million while also increasing their total income.
• Without our comprehensive system of community based supports our state would be spending an additional $580 million to maintain institutional alternatives. Most of the states in the nation still rely on a combination of such programs. All communities in Vermont are stronger because everyone is included. (This cost estimate is based on 2,917 people served with an average per person cost of $56,672 HCBS vs. $255,692 for institutional care – Braddock, 2013)
• Spending: Vermont ranks in the middle of the New England states in spending of state dollars (including Medicaid match) per state resident for intellectual/developmental disability (I/DD) services – and is higher than the national average, Vermont is ranked 15 nationally in state spending per capita.

How people are better off:
• Preliminary 2015 adult consumer survey results show people expressed a high degree of satisfaction with:

- where they live (86%)
- where they work (90%)
- deciding their daily schedule (90%)
- shopping (94%)
- going out to eat (84%)

• More Vermonters with disabilities are going on to post-secondary education than ever before and our "Think College-Vermont", "College Steps" and "SUCCEED" programs are helping them get there. Last year five colleges and universities issued 2-year certificates to 74 graduates. 76% of the SUCCEED program graduates went on to live independently.
• In FY 2014, 47% of working age people served by DDS home and community-based services were employed.
• In the upcoming year we will invest in strategies that will allow us to better understand and improve service satisfaction through measurement of personally defined outcomes. Using methods developed by the Council on Quality & Leadership, we will engage our community partners in learning methods for interviewing and gathering information that will further our state's proud tradition in promoting principles that support person-centered quality of life including self-determination, choice, and self-advocacy.

Here are some of the questions from Legislators:
Representative Toll wanted to know if all individuals have the same opportunities in different regions of the State. Monica said she is not sure if that is true for post-secondary options, because it's being developed. She also noted that DAs cooperate with each other and individuals are not shut out.

Representative Hooper said that her constituents are concerned about the diminishment of the services – can you reflect on the ability of DAs to meet needs when we are not giving inflationary increases? Monica replied that the reality of a level funded budget is that you are looking at the impact on infrastructure.
We are trying to address caseload need, but we are not looking at rate increases. Representative Hooper hears particularly from the DS population, particularly from people with high needs. Monica replied that we are trying to balance resources with needs.

Representative Fagan expressed concern about holding providers responsible for things they can't control such social life, happiness with the place they live. Representative Johnson joined in saying you should specify what you are responsible for and what you have a contributory role in.

Representative Johnson questioned at what point will an equilibrium be hit in which the caseload will stabilize. Julie Tessler explained the increasing incidence of autism, babies surviving with disabilities and people living longer with disabilities.

Department of Health Budget
When asked if there was one thing that could be done to prevent addictions, Commissioner Harry Chen said it would be to have healthy supportive connected families and communities and resilient individuals. He reviewed the determinants of health and highlighted how important behavior is. He believes we need to put health into all public policies and they are working across state government to achieve this.

He shared an article on a study that found middle-aged white Americans have rising death rates due to an epidemic of suicides and afflictions stemming from substance abuse: alcoholic liver disease and overdoses of heroin and prescription opioids. Vermonters are not equally healthy: Rutland, Bennington, Essex and Orleans are the least healthy counties. Addison, Lamoille, Chittenden and Washington are the healthiest. He noted that this can be correlated to income, education, tobacco use, etc. Majority (54%) of deaths can be traced back to no physical activity, poor diet and tobacco use.

Senate Health & Welfare reviews AHS Contracts with Designated, Specialized and Preferred Providers
Katie McLinn gave an overview on the language in S.196. It looks at performance measures and compares compensation of the DA/SSAs to equivalent services in the private sector. Ginny Lyons introduced the bill to put a system in place and to ensure resources are used efficiently and effectively. She wants to look at requirements of DAs and how they are reimbursed for what they do. She also wants to ensure that there are performance measures and that payments don't incentivize agencies to hold on to clients.

Julie Tessler voiced support of the legislation on behalf of VCP, but with a number of proposed language changes. She highlighted the positive work with the state on payment models and outcome measurements. She also spoke to the impact of the compensation differential with the public sector and the consequences to the people served in the designated and specialized service agencies (DA/SSAs). If the legislation moves forward with the proposed revisions it will require the State to compare compensation levels of the DA/SSAs and preferred providers with the private and public sectors; study the impact of low payment levels; and look at outcome and reporting measures required of DA/SSAs and preferred providers.

Selina Hickman of AHS spoke about the work being done with the master grant outcomes group. She appreciates the huge amount of work that the DA/SSAs have been shouldering. She explained how DA/SSAs are working with all Departments in AHS with 140 separate measures in the master grant. From October to December the workgroup reduced the required measures from 140 to 40 for the master grant that starts July 1, 2016. The agency is standardizing attachment A which was 400 pages long. The Departments are now all using the same templates.

Although the ultimate goal is to connect outcomes to payment, we are not at the point of tying payments to outcomes, yet, reported Selina. We are working on developing a value based payment process for DA/SSAs, after we decided not to move forward with the SAMHSA certified community behavioral health Center (CCBHC) grant. Instead, SIM resources are being utilized to develop a Vermont specific value based payment model that could fit into an integrated health care system. Through the DA/SIM/APM workgroup we are developing a new model that could look like an ACO capitated payment with risk. We are beginning with a risk assessment. PHPG is providing contractual support for payment

modeling and scope of services. Additionally, SIM is funding VCP to do provider readiness work. Senator Lyons expressed interest in future funding for this analysis.

Senator Lyons wondered why DVHA is not included in the master grant as DAs are being seen more and more as health care. Selina replied that the Medicaid program goes across AHS, not just DVHA. DVHA does the Medicaid state plan services and the other AHS Departments administer specialized Medicaid services which originally required waivers.

Selina described how AHS recently instituted a global commitment policy committee which reviews new or changed policies to improve consistency between departments. For the APM GMCB and office of health reform are negotiating the federal agreement. AHS and the Departments are looking more comprehensively at services that are not going to be regulated by the APM.

Senator Ayer asked how DVHA funding will be incorporated into the ACOs through the APM. She was informed that we have a shared savings program through DVHA now which contracts with the 3 ACOs. The ACOS are just a portion of the population covered by DVHA, because some enrollees see physicians who don't participate in an ACO or the Medicaid enrollees are dually eligible for Medicare; for these people DVHA pays fee-for-service.

Senator Ayer wondered if we are handing over control to ACOs for care of Medicaid enrollees. Selina, said we are looking at addressing this by making capitated payments with quality benchmarks required to receive the funding. The APM aligns how the payers make payment, so there are incentives for quality standard and improved outcomes through improved practices.

When questioned on how costs savings will be achieved, Selina responded that the incentives are based on population health, not on volume of services provided as in fee-for-service.

Deputy Commissioner for ADAP Barbara Cimaglio said they have a complex system at the health department to track outcomes, including The Healthcare Effectiveness Data and Information Set (HEDIS). Preferred substance abuse providers must meet minimum quality measures. It is complicated, but we are trying to work together. We are already using incentive payments for meeting quality measures, but not enough to make a difference admitted Barbara.

House Health Care Committee Studies the All Payer Model

Ena Backus, Assistant Director of the Green Mountain Care Board (GMCB) gave an overview of the All Payer Model (APM) and the recently developed term sheet, which is the initial agreement between CMS and Vermont. She said one of the major questions is whether the ACO can handle the level of risk for population based payment. The term sheet does not specify one or three ACOs. Although the term sheet specifies three waivers to Medicare rules, it does not limit further enhancement of Medicare services.

If the APM moves forward GMCB will evaluate Medicaid rates for ACOs, but will not have authority to set the Medicaid rates. DVHA would set its own rates. The care delivery model should be broader than the Medicare part A and B services that are included in the financial model with a capped spending trend. Only 34% of Medicaid services are for Medicare type A and B services.

The goal of the new model is to improve health care integration and there is a hope of creating additional services beyond Medicare part A and B. Medicare part D benefit is for pharmacy and is more

complex. The pathway for assessing readiness of inclusion of additional services involves evaluation of: payer and provider readiness; health information technology; and federal readiness.

House Health Committee Hears from OneCare

The Executive Director of OneCare Todd Moore gave an overview of ACOs and how they impact both quality and cost to Medicare. He spoke about individuals on Medicare who were identified as having complex needs, in addition to nearly 2,000 people who were already being served by community providers for care coordination using informatics created through OneCare.

He noted that Medicare will agree to pay by capitation instead of fee-for-service through the Next Generation waiver. OneCare had to commit to aligning other payers into value-based contracts, similar to the APM. The Next Generation program has similar waivers for both benefits and fraud and abuse requirements as the APM waiver.

OneCare is happy with the Vermont APM waiver. The discount with hold harmless minimums is more generous than the Next Generation waiver and floor of 2% is also a bonus. APM also enables the continuation for the Blueprint for Health and SASH. The quality measurement for All Payer for population health, are positive as well.

The system goals to reduce chronic disease could be challenging. It is unclear if OneCare needs to apply to GMCB for participation or if Next Gen acceptance is enough. When questioned 'what if OneCare can't attract enough providers for significant numbers of attributed lives', he replied that it would be best to have 300,000-400,000 Vermonters in an ACO. That would require all three ACOs to come together.

The cost of the ACO would be $9 million, because they need to take on risk and enrich quality improvement including informatics. It's going to be tough to make it attractive for local providers to put resources into the ACO infrastructure. Vermont insurers and DVHA will still need infrastructure, because not all Vermonters will be attributed to the ACO.

If the APM doesn't go forward, OneCare may try to develop value-based contracts with DVHA and the private insurers.

Vermont Care Organization has not yet been formed, but would be developed by the three existing ACOs. It would then need to reach out to the providers. It feels like OneCare is pushing this agenda, more than the other ACOs. This would be a self-governing and self-regulating organization. He sees it as a logical next step.

Todd believes that the Vermont Care Organization could support the development of community integrated healthcare:

- Health population centered
- Population health focused strategies
- Integrated networks linked to community resources capable of addressing psychosocial/economic needs
- Population-based reimbursement
- Learning organization: capable of rapid deployment of best practices
- Community health integration
- E-health and telehealth capable

He doesn't think the other ACOs are big enough to take on risk this on their own. Plus, they would need to develop more infrastructures and it would be harder to integrate at the community level.

Ena Backus spoke about consumer protections that are already in the Medicaid, Medicare and commercial shared savings program. As the Next Generation or the APM ACO is developed similar standards will be established.

1. Consumers must be represented in the governance of the ACOs
2. Consumer advocate must participate in the governance body
3. There will be regional representatives on the governance body
4. Transparency provisions: open meetings, availability of minutes, allotted time for public comment periods at governance meetings
5. Consumer advisory board
6. Robust quality measurement
7. Outcome measures
8. Access standards for medically necessary services
9. Grievances and Appeals are addressed through the payer/insurer
10. Provider choice consistent with their health benefit plan

Vermont's Health Care Advocate Trinka Kerr noted that currently commercial insurers handle appeals. If a consumer loses after two rounds a consumer can request the state to set up an independent review. An independent panel hears the consumer's and physician's perspective. Medicaid has a separate process that can end up in the court system and Medicare appeals can end up at an administrative law judge.

Trinka would like an internal review with the physician, in which the provider would have to give an explanation for a denial. The next step would be for the ACO to review the decision and then an appeal could be made to an independent review organization which could be handled by the GMCB and they could have an independent review board consider the appeal. Trinka thinks that the person would then need to go back to the payer. Trinka sees this as important given the incentives to reduce health care spending.

Funding increases in the Department of Health budget include: narcan, syringe exchange and state employee salary and benefits.

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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