Vermont Council of Developmental and Mental Health Services
Legislative Wrap Up for the 2014 Session

The Appropriations Act

Agency of Human Services

Medicaid Rate Increase

The 3% Medicaid rate increase implemented in October 2013 was annualized with $9.3 million in the FY'15 budget. Additionally, the Legislature approved a 1.6% Medicaid rate increase effective January 1, 2014.

The following Medicaid language was agreed to:

> By December 31, 2014, designated and special service agencies who receive global commitment funds for Medicaid reimbursement rate increases shall provide the Agency of Human Services their proposed allocation of these funds. By January 15, 2015, the Agency shall provide the House and Senate Committees on Appropriations a consolidated report of the proposed allocations.

While the Council had hoped to avoid language altogether, we have been assured that this language will not prevent each agency from strategically allocating the funds as necessary.

Future Reimbursement Rates

The budget calls for the following language relevant to Medicaid reimbursement rates which speaks to future inflation trends.

> Sec. E.306 32 V.S.A. §
> 307(d) is amended to read:
> (d) The Governor's budget shall include his or her recommendations for an annual budget for Medicaid and all other health care assistance programs administered by the Agency of Human Services. The Governor's proposed Medicaid budget shall include a proposed annual financial plan, and a proposed five-year financial plan, with the following information and analysis:
> * * *
> (5) health care inflation trends consistent with provider reimbursements approved under 18 V.S.A. § 9376 and hospital budgets approved by the Green Mountain Care Board under 18 V.S.A. chapter 221, subchapter 7 expenditure trends reported under 18 V.S.A. § 9375a;

For reference purposes:

> § 9376. Payment amounts; methods
> (a) It is the intent of the general assembly to ensure payments to health care professionals that are consistent with efficiency, economy, and quality of care and will permit them to provide, on a solvent basis, effective and efficient health services that are in the public interest. It is also the intent of the general assembly to eliminate the shift of costs between the payers of health services to ensure that the amount paid to health care professionals is sufficient to enlist enough providers to ensure that health services are available to all Vermonters and are distributed equitably.

Home Care Union

The budget includes the last minute addition of $2.2 million in general fund (GF) for the home care workers. At this time, the Home Care Workers have not yet ratified this contract. If the contract is ratified the union will receive an agency fee of 2% of the direct care worker salaries. The workers' increase this year will be 2.5% with a floor of $10.80/hr. So some employees will net only a .5% increase. Additionally, the daily respite rate will be raised to $150/day. Workers covered by the union include: Choices for Care workers, Personal Care Workers, DS workers on the ARIS payroll (not our salaried employees) and attendant services workers. Due to the support of the Commissioner of Finance and Management, these funds are separate from the Medicaid Rate increase, so it doesn't dilute and instead supplements the Medicaid funds for 1.6% provider increases.

Substance Abuse Services

As part of the Governor's Opiate Initiative $8 million in total funds will be directed to the Hub and Spokes for Opioid treatment to be funded through savings achieved when individuals have the opiate addictions treated. The Council, among other advocates and providers, continues to have questions regarding the state's sources of expected savings: ADAP residential, ambulance, clinic, DME, home health, independent lab, inpatient, outpatient, pharmacy, PT, MD, psychology, and RHC/FQHC. The Legislature's dissatisfaction with the answers about how these funds were going to be saved resulted in the following language in the budget.

(c) Transfer of Global Commitment Funds:
(1) Subsequent to meeting the requirements of subsection (a) of this section, the Secretary of Administration and the Chief of Health Care Reform are authorized to transfer Global Commitment funds from the Department of Vermont Health Access (DVHA) to the Office of Alcohol and Drug Abuse Programs for the Care Alliance for Opioid Addiction. A written notification shall be submitted to the Joint Fiscal Committee for funds transferred under this subdivision and shall include a description of the specific use of funds within the Care Alliance for Opioid Addiction consistent with the objectives identified in subsection (a) of this section
(2) Anticipated or identified savings in DVHA or other departments of the Agency of Human Services identified as a result of the increased expenditures through the Care Alliance for Opioid Addiction shall be included in the notification set forth in subdivision (1) of this subsection.

The Council advocated for the necessary financial resources to achieve the opiate initiative, particularly for the preferred providers to do assessments and treatment. H.29 would have enabled licensed alcohol and drug counselors (LADCs) to receive Medicaid reimbursement for clinical and case coordination services, regardless of whether the counselor is a preferred provider. The legislation passed the House Human Services Committee as a way to improve access to substance abuse services, but was blocked by the House Appropriations Committee due to concerns about the unknown costs to the State. The Council recommended that developing better methodologies for financing services provided by designated agencies and preferred providers be the first step in addressing access challenges. At our request the Appropriations Act calls for a study of financial methodologies for substance abuse services:

(d) Payment Methodology:
(1) On or before March 15, 2015, the Chief of Health Care Reform, Secretary of Human Services, and Commissioners of Health and of Vermont Health Access shall submit to the House and Senate Committees on Appropriations, the House Committee on Human Services, and to the Senate

Committee on Health and Welfare a report on designing the payment methodology for substance abuse and mental health services to achieve the objectives in subsection (a) of this section. The report shall include the benefits, drawbacks, and costs of:
(A) rate setting;
(B) capitated funding;
(C) performance-based contracts;
(D) cost-based reimbursement;
(E) capacity grants; and
(F) bundled payments.

The following language relates to the desire of the legislature to have clearer outcomes for substance abuse services and a greater connection to the comprehensive health services. The Chair of the Appropriations Committee, Senator Kitchel, was so frustrated with the work of ADAP that she led the Senate to approve moving the Office of Alcohol and Drug Abuse Programs (ADAP) to DVHA. This language was agreed to as a compromise with the House.

Sec. E.306.2 SUBSTANCE ABUSE TREATMENT SERVICES
(a) Program Objectives and Performance Measures:
(1) On or before September 15, 2014, the Chief of Health Care Reform, the Secretary of Human Services, and the Commissioners of Health and of Vermont Health Access in consultation with the Chief Performance Officer shall submit to the Joint Fiscal Committee, the House and Senate Committees on Appropriations, the House Committee on Human Services, and to the Senate Committee on Health and Welfare the program objectives for the State's substance abuse treatment services and three performance measures to measure success in reaching those program objectives.
(2) Thereafter, annually, on or before January 15, the Chief, Secretary, and Commissioners shall report to those Committees on the service delivery system's success in reaching the program objectives using the performance measure data collected for those services.
(b) Comprehensive Service Delivery System:
(1) On or before November 15, 2015, the Secretary of Administration and the Chief of Health Care Reform, in consultation with the Secretary of Human Services, shall report to the Joint Fiscal Committee, the House and Senate Committees on Appropriations, the House Committee on Human Services, and to the Senate Committee on Health and Welfare on current and additional strategies to achieve a more comprehensive health care service delivery system based on a greater integration of substance abuse payment and care coordination with physical and mental health. Recommendations may include organizational restructuring within the Agency of Human Services.
(2) The Secretary of Administration and the Chief of Health Care Reform are authorized to initiate recommended organizational restructuring if approved by the General Assembly or, if the General Assembly is not in session, by the Joint Fiscal Committee.

Department of Vermont Health Access

Autism Services

This budget includes $1.6 GF for autism services and $168,000 in total funding for 2 positions to manage the services.

Department of Disabilities, Aging and Independent Living
The new Caseload request was developed by the Joint Fiscal Office who consulted with the Council on its calculations. The Council is satisfied that the $8.7 million in total funds request will be sufficient.

Department of Children and Families
DCF continues the roll out of substance abuse and mental health counselors with $1.2 million in total funds for substance abuse and mental health services for Reach-Up clients through Designated Agencies.

Department of Corrections
Included in the budget is $760,000 per the pretrial services bill, for pretrial monitors to screen and provide support to individuals either pre-charge or pre-arraignment. These funds will be contracted out and the DAs through BHN-Vermont could potentially provide this service.

Department of Mental Health
The federal Youth in Transition Grant will run out on September 30, 2014. The Legislature appropriated $175,000 in general funds, which will sustain 44% of the program going forward. The Council supported the request for fully funding the continuation of the program and youth from throughout the state did a wonderful job advocating as well.

Additional highlights to the FY'15 DMH budget include:

- $50,000 in total funds for Kirby house for adding nursing services;
- $ 1.1 million in total funds increase for PNMI to address increased demand;
- SFI funding is being reduced, but 6 clients will be maintained in the DMH budget;
- $400,000 total funds for the new residential program in Rutland
- $7.5 million increase in total funding for Success Beyond Six program at no net cost to GF

There is significant concern about the funds invested in Act 79 and the Vermont State Hospital. Therefore specific reporting measures were put in the DMH Budget.

> Sec. E.314.1 MENTAL HEALTH BUDGET PRESENTATION
> (a) In order for the General Assembly to evaluate whether the State is meeting the goals in 2012 Acts and Resolves No. 79 of increasing community supports, decreasing inpatient care, and moving toward a less coercive system and to evaluate the outcomes of the system wide investments made as the result of Act 79, the Departments of Mental Health and of Vermont Health Access shall in consultation with the State's Chief Performance Officer, as designee of the Secretary of Administration, provide a longitudinal capacity, caseload, expenditure, and utilization analysis with the fiscal year 2016 budget presentation for:
> (1) Inpatient Services by the following funding categories:
> (A) Level 1 inpatient psychiatric services;
> (B) other involuntary inpatient psychiatric services;
> (C) inpatient psychiatric services for community rehabilitation and treatment clients;
> (D) inpatient psychiatric services for other Medicaid patients; and treatment clients;
> (E) emergency department wait times for an acute inpatient psychiatric bed for minors and adults.
> (2) Residential Services by categories of service, including:

(A) Intensive Recovery;
(B) Crisis Residential and Hospital Diversion;
(C) group homes;
(D) supported independent living; and
(E) secure residential.
(3) Community Mental Services by categories of service, including:
(A) community rehabilitation and treatment;
(B) crisis programs;
(C) outpatient clinics; and
(D) peer support programs.
(4) Other Mental Health Support Services and Administration.

Health Reform Oversight

There is growing concern about health reform and the need for legislative oversight. The following language empowers the chairs of the money committees to have a larger role and sunsets the current Health Care Oversight and Mental Health Oversight Committees.

Sec. E.306.3 2 V.S.A. chapter 20 is added to read:
CHAPTER 20. HEALTH REFORM OVERSIGHT COMMITTEE
§691. COMMITTEE CREATION
There is created a legislative Health Reform Oversight Committee. The Committee shall be composed of the following six members:
(1) the Chair of the House Committee on Appropriations;
(2) the Chair of the Senate Committee on Appropriations;
(3) the Chair of the House Committee on Ways and Means;
(4) the Chair of the Senate Committee on Finance;
(5) the Chair of the House Committee on Health Care; and
(6) the Chair of the Senate Committee on Health and Welfare;
§ 692. POWERS AND DUTIES
(a) When the General Assembly is adjourned, the Committee shall provide legislative oversight and review of revenue collection, expenditures, and planning related to health care reform efforts in Vermont.
(b) When the General Assembly is adjourned during fiscal year 2015, the Commissioner of Vermont Health Access shall provide monthly updates regarding Vermont Health Benefit Exchange operations, enrollment data, coverage status, customer support, and Exchange website functionality.
(c) Effective on January 1, 2015, all reports previously submitted to the Health Care Oversight Committee shall be submitted to the Health Reform Oversight Committee.
§ 693. ASSISTANCE
(2) If applicable, the Secretary shall submit an electronic report to the Joint Fiscal Office for distribution to members of the Committee that summarizes any plans or actions taken by the Executive Branch to delay health care reform project schedules as a result of:
(A) increased costs exceeding official estimates;
(B) changes in the consensus revenue forecast of the Health Care Resources Fund;
(C) changes in the availability of federal funding; or
(D) any other changes related to the planning for and implementation of health care reform as directed by 2011 Acts and Resolves No. 48.

Sec. E.306.4 REPEALS
(a) 2 V.S.A. chapter 24 (Health Care Oversight Committee) is repealed on January 1, 2015.
(b) 2004 Acts and Resolves No. 122, Sec. 141c (Mental Health Oversight Committee), as amended by 2006 Acts and Resolves No. 215, Sec. 293a and 2007 Acts and Resolves No. 65, Sec. 124b, is repealed on January 1, 2015

Policy Legislation

Pretrial Services

S.295 the Governor's opiate initiative and pretrial services bill, based on Council advocacy, will be inclusive of mental health as well as substance abuse services. When individuals are screened pre-charge or pre-arraignment and the indicators show negative for criminal risk and positive for mental health or substance use disorders, they will be referred to designated agencies for clinical assessment. They may then be referred for medication assisted treatment at a Hub or Spoke, or treated by a designated agency or preferred provider. The adequacy of funding for these services at Designated Agencies continues to be unclear, but the program will be rolled out over time and this is thought to allow time to work through how services will be financed. Here are the mandates, directives, and recommendations that are relevant to our system of care:

- General Assembly urges Administration to ensure access to medication assisted treatment (MAT) while taking measures to avoid diversion and misuse
- Administrative Judge and Court Administrator, in consultation with AHS, shall develop statewide phased rollout plan of specified groups. Plan to be submitted to Corrections Oversight Committee on or before October 15, 2014.
- DOC to select screening instruments and have them available by September 1, 2014
- DOC to provide or contract for pretrial monitors
- AHS, with Criminal Justice Capable Core Team, to map regional services
- DOC, with MAT for Inmates Work Group, shall develop MAT plan for incarcerated persons
- DOC to include substance abuse and mental health services in RPF for inmate health services
- DOC to report to Corrections Oversight Committee during 2014 interim on progress toward selecting inmate health services

Developmental Services System of Care Plan

H.728 has been passed by the Legislature and will include language requiring that sections of the System of Care Plan go through the legislative rules committee. This is important because the Commissioner of DAIL sets the priorities for who is eligible for services and what services are available through the annual updates of the System of Care Plan. The legislation will:

- increase legislative oversight in this process
- clarifies the process for annual updates
- strengthens expectations for quality assurance and monitoring
- requires the annual reporting to include information on the needs of people not served and waiting lists

Policy on Autism Services

There was much discussion about the role of Applied Behavioral Analysis, the need for a certification or licensure process in Vermont and the role of independent providers verses designated and specialized service agencies in the House Health Care Committee. The House Health Committee wrote the House Government Operations Committees to request that the Office of Professional Regulation look into licensure for individuals with ABA training. This could enable them to access Medicaid reimbursement in the future. They wrote, "licensing BCBAs would further the goal of providing medically necessary services to children with developmental disorders, including autism spectrum disorders, in a safe and effective manner."

Additionally the House Health Committee questioned Blue Cross/Blue Shield and MVP insurance about reimbursement for designated agencies after hearing testimony on the challenges that our agencies are having with receiving payments from the insurance companies.

Workers' Compensation Changes, S.220

Changes to the workers' compensation program were made in the final days of the session. Provisions added to the omnibus economic development bill will:

- Limit employers from scheduling independent medical examinations to within a two hour driving distance of the employee/claimant
- Extend the allowed time an injured worker has to seek an extension if discontinuance is ordered but disputed to 14 days
- Change the way an employer and workers' compensation insurance carriers are reimbursed for benefits paid when there is a lawsuit against a third party

Minimum Wage Set to Increase to $10.50 over 4 Years, H.552

The minimum wage will increase to $9.15 in 2015, $9.60 in 2016, $10.00 in 2017 and, finally, $10.50 in 2018. The cost of living adjustment currently increases the minimum wage every year, but will be eliminated during these set increases in 2017. The current minimum wage is $8.73 in Vermont and $7.25 at the federal level.

Traumatic Brain Injury

H.555 addresses individuals who are incompetent to stand trial because of a traumatic brain injury, mental illness or intellectual disability. It directs that they be sent to the least restrictive environment for an examination and allows for an examination on an outpatient basis for mental competency. The Department of Disabilities, Aging and Independent Living shall report to key legislative committees on the Department's progress in evaluating best practices for treatment of persons with traumatic brain injuries who are unable to conform their behavior to the requirements of the law, and in identifying appropriate programs and services to provide treatment to enable those persons to be fully reintegrated into the community consistent with public safety, particularly for persons who have been found not guilty by reason of insanity or incompetent to stand trial. DAIL shall request funding through the Global Commitment Waiver. To the maximum extent possible, the Department shall design the program to be integrated into the Department's existing framework of services.

Health Reform and ACE

In H.596 which includes much of the language originally in S.252 there is much focus on financing for Green Mountain Care and includes a number of health care topics including a requirement that the Secretary of Administration recommend to the House Committees on Health Care and on Human Services and the Senate Committees on Health and Welfare and on Finance whether and to what extent to increase payments to health care providers and community health teams for their participation in the Blueprint for Health and whether to expand the Blueprint to include additional services or chronic conditions such as obesity and mental conditions. Additionally, on or before January 15, 2015, the Director of the Blueprint for Health and the Chair of the Green Mountain Care Board or their designees shall review evidence-based materials on the relationship between adverse childhood experiences (ACEs) and population health and recommend to the General Assembly whether, how, and at what expense ACE-informed medical practice should be integrated into Blueprint practices and community health teams. The Director and the Chair or their designees shall also develop a methodology by which the Blueprint will evaluate emerging health care delivery quality initiatives to determine whether, how, and to what extent they should be integrated into the Blueprint for Health. The Council is supportive of this language.

Designated Agencies, Health Homes and ACOs

The Council educated legislators on Health, Human Services and Appropriations Committees about ACOs and how their development will impact the disability long term services and support system of care in general and the designated and specialized service system in particular. We pointed out the opportunity to enhance integration of physical and mental health care. We reviewed important aspects of community-based care which must be preserved and explained critical aspects of work between DA/SSAs and ACOs. Our biggest concern is about maintaining the integrity of our work and our mission to serve vulnerable Vermonters with complex needs. We also informed legislators of the work the Council and BHN are doing to develop models for designated agencies to serve as health homes for individuals with significant mental health, developmental disabilities and substance use disorders that would prefer to use us as their primary setting to receive and coordinate health care. We present ourselves as active participants in and fully support Vermont's systemic and shared consensus approach to health reform.

Government Accountability

S.293 was passed into law. It requires the executive branch to report on population-level outcomes and indicators for different areas of State government and on the performance measure pilot program in order for the General Assembly to consider data-based results in decisions. The Council was supportive of the legislation and educated key legislators about our work on outcomes using results based accountability.

SFI Designation

Act 123, formerly H.690 limits the definition of serious functional impairment (SFI) to apply only to individuals residing in correctional facilities and not to individuals reentering the community after incarceration. The Agency of Human Services retains its mandate for enhanced discharge processes with a statewide SFI committee and local teams that look at the SFI populations. It is implementing a planning grant to improve this process. The SFI designation entitles individuals to certain protections and access to services within facilities. The Council was supportive of the bill.

The SFI Legislative Committee Report focused on community supports, including people with public safety risks. The recommendations of interest include:

- SFI designation should only be used within correctional facilities
- Reentry planning will be based on tools that measure functioning and risk
- The contract for health care services should be with in-state providers to improve continuity of care
- There should be exploration of how to reimburse DAs for reentry planning
- Expand the use of the sequential intercept to achieve statewide coverage, especially treatment