



Legislative Agenda for 2020 Working Draft 2

Maintaining our Commitment to Vermonters

Designated and Specialized Service Agencies (DA/SSAs) are nonprofit community-based agencies doing the work of the state to meet mental health developmental disability and substance use disorder needs of Vermonters. Our comprehensive array of services addresses the social determinants of health including clinical care, community supports and crisis services on a 24/7 basis. By statute, "*Vermont's mental health system shall be adequately funded and financially sustainable to the same degree as other health services.*" Yet, the State has not provided adequate funding for our workforce to fully achieve the outcomes the State requires. In 2017 this language was added to the statutes:

18 V.S.A. § 8914 Rates of payments to designated and specialized service agencies (Act 82, 2017)

(a) The Secretary of Human Services shall have sole responsibility for establishing the Departments of Health's, of Mental Health's, and of Disabilities, Aging, and Independent Living's rates of payments for designated and specialized service agencies that are reasonable and adequate to achieve the required outcomes for designated populations. When establishing rates of payment for designated and specialized service agencies, the Secretary shall adjust rates to take into account factors that include:

(1) the reasonable cost of any governmental mandate that has been enacted, adopted, or imposed by any State or federal authority; and

(2) a cost adjustment factor to reflect changes in reasonable costs of goods and services of designated and specialized service agencies, including those attributed to inflation and labor market dynamics.

(b) When establishing rates of payment for designated and specialized service agencies, the Secretary may consider geographic differences in wages, benefits, housing, and real estate costs in each region of the State. (Added 2017, No. 82, § 11, eff. June 15, 2017.)

Vermont Care Partners' intent is to bring the language of this statute into reality. We will also work in coalition with other human services providers who have similar challenges with being under-resourced.

PRIORITIES

1. Appropriations Bill for Fiscal Year 2020

Increase the Medicaid Reimbursement Rates by 3%

Vermont Care Partners requests a workforce investment for all staff. These funds could be used to target compensation increases to the most critical positions to meet community needs, address local labor market dynamics, and cover health benefit costs.

- After years of insufficient investment in DA/SSAs the State needs to create parity in funding with physical health care and then provide for annual funding increases for DA/SSAs in the context of annual increases for state employees, health care and school employees.
- Designated and Specialized Service Agencies (DA/SSA's) rates of reimbursement are insufficient to cover costs. There is no direct correlation between payment rates and actual cost of services
- The mental health challenge of patients in Emergency Departments cannot be solved without an investment in the community-based service to ensure adequate access to upstream services and to prevent people from getting stuck in inpatient care due to inadequate resources in the Community
- Staff turnover and vacancy rates are still at critical levels with nearly 1 in 5 licensed clinical positions vacant and over 400 vacancies system wide.

Developmental Services Caseload Budget

Vermont Care Partners wants to ensure adequate funding for services provided to people with intellectual and developmental disabilities, both those currently served and those people who newly require services. From 2006 to 2016, the number of persons eligible for intellectual and developmental disability waiver services rose by almost 50%. This continual upward trend requires new money, referred to as caseload funds and this new funding is essential each year.

Substance Use Disorder Services

Vermont Care Partners will support and educate on the continuing demand for opiate and other substance use disorder outpatient treatment and the need for reimbursement rates predicated on costs, and expanded access to services. Every single DA is losing money in SUD programs. In FY19 the total system loss was \$2.2million on \$15.2million in programming for a 15% loss. We support the continuation of the AAP credential to expand the workforce.

Elder Care

Research demonstrates older people with mental illness have twice the medical cost of those who do not have a mental illness and that when mental illness is treated, physical health improves. Shoring up the Eldercare program will save the state money in medical costs for its growing population of folks 60 and older. Additionally, these services prevent use of higher cost care by enabling older Vermonters to remain independent longer and avoid or delay nursing home placement. It's been 20 years since \$250,000 was appropriated for eldercare clinicians to address the growing mental health of elders and the appropriation is now only \$235,000 while at the same time elders are facing more and more social isolation leading to rising rates of mental health and addiction service needs as noted in the State Plan on Aging. We recommend adding just \$145,000 which is equivalent to a 2% increase over the life of the program. This would improve the ability of Agencies to train, hire and retain qualified specialists to provide community based mental health services. Additionally, we continue to urge the Agency of Human Services to request a waiver from the federal government to enable all masters' level clinicians (not just MSWs) to be reimbursed by Medicare through the All Payer Model. This would expand the labor pool and help keep the programs fiscally sound. The Administration added \$50,000 in the FY21 budget request which we support.

2. Developmental Services Systems Change

The system of care for individuals with intellectual and developmental disabilities is undergoing enormous change. Conflict of Interest Free Case Management requirements of the federal government may lead to different care models and agency responsibilities. Value-based payment will change how services are funded and a new assessment form and process may impact services received by

individuals. Vermont Care Partners will educate legislators about the proposed changes, share our recommendations and identify potential risks to the people serviced. Vermont Care Partners supports the development of an ombudsman to assist individuals who use services with questions and concerns. This would be similar to the Vermont Health Advocate and Mental Health Ombudsman which are located at Vermont Legal Aid. Language will be proposed in the House budget bill about the rates of systems change; setting limits on changes to those required by the State Auditor and CMS. Vermont Care Partners supports this language.

3. Green Mountain Care Board Fiscal Review of DA/SSAs

The Green Mountain Care Board is charged with reducing the rate of health care cost growth in Vermont while ensuring that the State of Vermont maintains a high quality, coordinated and accessible health care system. They review and approve the budgets of the State's hospitals, and OneCare Vermont, as well as approving the rates for commercial health insurance, annually. Given their purview of overseeing the State's health care system, including their responsibility for meeting the terms of the All Payer Model, Vermont Care Partners recommends that the Board review the fiscal status of the DA/SSAs similar to the reviews called for in Act 53 that established abbreviated fiscal reviews of the Vermont Psychiatric Care Hospital and the Brattleboro Retreat, plus ambulatory care centers. Fuller knowledge about the full array of Vermont's health care expenditure will lead to better perspective on health care expenditures, including where investments are most needed. This language has been added to S.290 which Vermont Care Partners fully supports.

4. Health Reform

Designated and Specialized Service Agencies are already generating millions of dollars of Medicaid savings on a statewide basis through mobile crisis services, crisis beds, substance use disorder services, residential and community-based supports for children, youth and adults, and participation in OneCare and Blueprint Care Collaboratives. These savings can be expanded with the right investments.

The IMD waiver application requires the State to demonstrate maintenance of effort with community-based service. There should be a balance in new spending between new inpatient beds and community-based mental health services given that upstream services will prevent both increased demand for inpatient care and over utilization of hospital emergency departments. Local pilot programs are achieving savings and promising results through improved care coordination, enhanced referral, integrated care and utilization management. Vermont Care Partners is interested in sustainability and expansion of successful pilot programs.

The expertise, knowledge and relationships with high needs populations is at DA/SSAs who play a critical role in improving health outcomes for Vermonters with complex and costly health needs by addressing the social determinants of health with a whole person-directed approach. National data shows that over 40% of health care costs are related to co-occurring mental health and substance use disorder conditions. In European countries where more resources are directed to human services and the social determinants of health, medical costs are far lower. DA/SSAs could create further Medicaid savings by expanding the scope of populations and services offered

5. Emergency Room Back-up and the Build out of Inpatient Psychiatric Beds

The back-ups and long lengths of stay for adults and children in hospital emergency rooms is an egregious situation. Some children are being sent back home while awaiting inpatient care who would benefit from more immediate intervention. Diversion programs are cost-effective approaches to

reducing back-ups in emergency rooms. The State is planning to expand the number of inpatient beds. This planning should be done in the context of the full continuum of mental health care.

DAs/SSAs already have a track record - when Vermont expanded the number of crisis bed programs through Act 79, the number of CRT inpatient days dramatically decreased. Crisis beds cost on average \$693/day compared to \$2,625/day for Vermont Psychiatric Care Hospital. We estimate a savings of \$6 million annually just in inpatient services due to the existing crisis bed programs.

We need to shore up funding for the community mental health system, especially crisis and subacute services, as the key to addressing emergency department back up and to avoid building more inpatient beds than we really need. Upstream services are always what people prefer to use and are more cost effective. Downstream services which enable Vermonters to be discharged sooner from inpatient care are also a critical component of the care system.

1. Raise reimbursement rates for the designated and specialized services agencies so that salaries are on par with state employees and other health professionals to reduce vacancies and turnover of staff at all levels of care. Outcomes: greater capacity in crisis and stepdown facilities; higher quality and better treatment available in the community to prevent hospitalizations (i.e. case management, outpatient therapy, and community supports); higher capacity for quality crisis interventions in the community to prevent ED visits.
2. Expand step-down facilities, secure residential care, intensive residential services, supported housing and peer-based services to reduce the length of stay in inpatient facilities and improve the flow of people through the acute level of care. Additionally, increase capacity for people with geropsychiatric needs. This could be done by developing a tiered rate system that incentivizes nursing homes to accept people with geriatric and psychiatric needs; increased coordination and shared care management between Choices for Care and DAs; and/or additional funding to establish nursing and/or primary care staffing in designated agency long term residential care homes. Outcome: More capacity for people stuck in inpatient care will open up Level One beds for those waiting in Emergency Departments.
3. Designated hospitals should be incentivized to accept high acuity patients, as well as patients who are in Emergency Departments outside their catchment area. A centralized admissions process would allow for inpatient units to provide input on concerns about accepting high-acuity clients, but will ensure that all available inpatient beds are available to be accessed. Outcome: better dispersal of people in need of hospital-level care to available beds.
4. Designated agencies, designated hospitals, EDs, and DMH care management should develop a set of communication protocols to track those waiting for hospital placement and those waiting to discharge. These protocols will include internal and system-wide operations. This group should give consideration to including those waiting for voluntary, as well as involuntary treatment. Outcome: by increasing awareness of clients stuck in ED or inpatient hospital settings among direct care staff, case management, and leadership, the instinct to protect against risk will be balanced by a culture of accountability and risk-sharing at all levels of the system, reflecting an attitude of zero tolerance for long waits in Emergency Departments.

6. Special Education

Our school-based services can be a solution to some of the problems raised by both rising special education costs and increasingly dysregulated student behavior in some of the following ways:

- For both our school-based services and our independent schools, our funding model leverages Medicaid Match so that schools pay only a portion of the cost of behavioral supports that the highest-intensity students;
- The innovative MTSS [Multi-tiered Services and Supports and PBIS [Positive Behavior Intervention and Supports] contracts that we provide in several schools fit well with a census-based approach because they are designed to support the emotional-behavioral needs of the whole student body preventatively;
- Spending decisions for school-based services should continue to be made at the local level while maintaining current Agency of Human Services, Agency of Education and Department of Mental Health oversight.
- Our 14 therapeutic independent schools are a necessary part of the continuum of special education services. These are not general education independent schools, but schools specifically designed to serve students with emotional, behavioral, and developmental disabilities.

The Workgroup on a census funding model should recommend incentivizing the use of early, preventative behavioral supports and establish a cost-effective process for extraordinary cost reimbursement. We can contribute our expertise in building integrated contracts that leverage Medicaid dollars through the mental health system to do both.

Specific advocacy efforts will include:

- Educating on the value of independent therapeutic schools;
- Educating on the value of Success Beyond Six school-based mental health services; and
- Addressing the special education rate criteria process.
- Support for the continuation of the Council of Independent Schools

ADDITIONAL ISSUES

1. State Holiday Commemorating the Closure of Brandon Training School (H.332)

In November of 1993 Brandon Training School was closed making Vermont the first state in the nation to both close our institution for people with developmental disabilities and establish a totally community-based system of care. This event was a milestone in the history of Vermont and speaks to our continuing values and efforts to promote a Vermont that works for all of us. All Vermonters, including people with disabilities, deserve to live with dignity and respect, and the freedom to make their own life choices. After 25 years Vermont is only one out of 11 states that have closed their institutions in favor of a fully inclusive community-based service system. The decisions of yesterday and our ongoing values should be celebrated and never taken for granted. The proposed holiday would not involve a shutdown of work sites, but simply a day of appreciation for our current services and the progress we have made to achieve full community

2. Woodside Juvenile Detention Center

The Agency of Human Services has recently announced its intent to close Woodside Juvenile Detention Facility. This is a major policy decision which will require significant analysis and consideration by state government and stakeholders.

From the perspective of Vermont Care Partners we are increasingly concerned about the growing number of youth with high acuity mental health needs. Some of these youth have been sent to out-of-state facilities because they can't be served in group home or other community settings due to aggression requiring more secure setting. Some residential programs in Vermont have already felt the burden of the decrease in use of Woodside. It is having a detrimental impact on the milieu in these programs which will continue if programs are asked to manage these very challenging youth exhibiting unsafe and dangerous behaviors. Restraints have increased in some programs as a result. What supports will the State be offering to community-based programs to manage these increased demands and intensity? A public-private partnership to oversee this programming, as presented in a report to the Legislature in January 2019 by DCF Commissioner Schatz should be considered.

There is also great concern about pushing these youth into to adult corrections. Youth who are 16 and older who commit certain crimes could be charged with a felony and served by the VT Department of Corrections. This would mean creating a separate space for them in the adult jail or sending them out of state. This raises many questions about how to best support youth in these environments and whether these are even appropriate environments for youth.

3. Mental Health Services for Offenders and those at risk

Vermont Care Partners supports improving reimbursement rates and expanding community resources to address mental health and substance use disorders of people who at risk or involved in law enforcement and corrections. We will encourage the legislature to take action to create a high-quality continuum of services to address individuals at-risk of involvement in law enforcement, individuals who are incarcerated and preventing recidivism of individuals released from incarceration. Proven model programs, such as treatment courts and the Sparrow program, have recently lost grant funding and are struggling to maintain their potential to reduce incarceration and address mental health and substance use disorders that create both individual hardship and public safety risks to our communities. Additionally, the Courts need adequate funding to participate in specialized programming. We are supportive of the recommendation that were made by Governor's Opioid Council to establish a Master to oversee court diversion programs.

We support the Justice Reinvestment Bill and see opportunities for DA/SSAs to address the mental health, developmental and substance use disorder needs of individuals under community supervision by the Department of Corrections.

4. Improving the Interface with the Criminal Justice System

There is growing concern about people who are found incompetent to stand trial or not guilty by reason of insanity. Recommendations were made by the ONH (orders of non-hospitalization) taskforce to better support individuals who are found incompetent to stand trial and are put on ONHs which honors their civil rights while addressing safety concerns of the public. We support S.183 on Insanity and Competency and look forward to participating on the forensic working group that the bill establishes. We support having the Attorney General's Office and Vermont Mental Health Law Project present at hospitalization hearings. One of the benefits would be better communication with the designated mental health providers to ensure a smooth and well-informed transition from the courts to community supports. We also support the recommendation to notify prosecutors where treatment is received and notifying them when the initial court order is expired. The bill also calls for notification of the state's attorney when individuals leave secure settings, so the victims may be notified.

5. Housing

A. Develop housing vouchers for People Served by the DS HCBS Waiver to create independent housing options for people with intellectual and developmental disabilities served in our home and community-based services waiver. This would improve choice and self-determination for the many adults who would prefer independent living options.

B. Improve the flexibility of the housing vouchers administered by the Department of Mental Health. Restrictive eligibility practices are leaving people in need homeless and housing vouchers underutilized.

C. We support the recommendations of the Coalition to End Homelessness

- Create 368 units of supportive housing over five years
- Increase the Supply of Affordable rental housing
- Support and expand programs that reduce homelessness

D. We have some concerns about the changes in administration of the general assistance housing program. We want to be sure that when the program is administered at the local level, that shortfalls in resources will still be addressed by state government. We support delaying the transfer of funds until April 1, 2021 per the House Appropriations Committee recommendation

6. Suicide Prevention

Vermont has the 11th highest rate of suicide in the country. It is a critical public health crisis. A number of our agencies are participating in the Zero Suicide initiative that has three goals: decreasing risk factors; early recognition of early signs of distress and mental health problems; and knowledge of effective steps to prevent self-harming behavior. This effort should be a State priority and we support expansion of the funding to enable all designated agencies and NFIb to participate in Zero Suicide.

7. Worker Compensation – Sole Contractor

We will monitor this issue, with the hope that it will not resurface and impact shared living providers. Should it resurface our goal will be to maintain the status of shared living providers as independent contractors, not as employees, for the workers compensation purposes.

8. Property Tax Reform

We will monitor to avoid any loss of tax-exempt status for our facilities.

9. Involuntary Psychiatric Treatment

The proposal to speed up the time frame for initiating involuntary treatment is likely to be brought to the Legislature as a tool to reduce emergency room and inpatient flow issues. Vermont Care Partners has not taken a position on the issue in the past and to-date members have not accepted the responsibility to directly administer involuntary medication.

10. Involuntary Sterilization

A bill has been introduced to repeal an archaic section of statute, Title 18 Chap 204: Sterilization which allows for the involuntary sterilization of a person with developmental disabilities. The existing statute, a throwback to the eugenics movement, is not in alignment with VCPs values of self-determination and choice. Although there might be some Vermonters who would object to the repeal of this law, Vermont Care Partners supports this bill and see this legislative action as a good opportunity to educate health providers about the rights of individuals with developmental and intellectual disabilities to exercise self-determination.

11. Minimum Wage

Vermont Care Partners is supportive of increases in the minimum wage as long as Medicaid rates are raised to accommodate the increased costs to community providers. Additionally, funding must also be appropriated to address wage compression so that staff with years of experience and more advanced expertise will have a wage differential from the entry level staff. Our experience with establishing a \$14 per hour minimum wage has been positive for the recruitment and retention of entry level staff.