1 TO THE HOUSE OF REPRESENTATIVES:
2 The Committee on Health Care to which was referred Senate Bill No. 133
3 entitled "An act relating to examining mental health care and care
4 coordination" respectfully reports that it has considered the same and
5 recommends that the House propose to the Senate that the bill be amended by
6 striking out all after the enacting clause and inserting in lieu thereof the
7 following:
8 * * * Findings and Legislative Intent * * *
9 Sec. 1. FINDINGS
10 The General Assembly finds that:
11 (1) The State's mental health system has changed during the past ten
12 years, with regard to both policy and the structural components of the system.
13 (2) The State's adult mental health inpatient system was disrupted after
14 Tropical Storm Irene flooded the Vermont State Hospital in 2011. The
15 General Assembly, in 2012 Acts and Resolves No. 79, responded by designing
16 a system "to provide flexible and recovery-oriented treatment opportunities
17 and to ensure that the mental health needs of Vermonters are served."
18 (3) Elements of Act 79 included the addition of over 50 long- and short-
19 term residential beds to the State's mental health system, all of which are
20 operated by the designated and specialized service agencies, increased peer
21 support services, and replacement inpatient beds. It also was intended to

1 strengthen existing care coordination within the Department of Mental Health
2 to assist community providers and hospitals in the development of a system
3 that provided rapid access to each level of support within the continuum of
4 care as needed to ensure appropriate, high-quality, and recovery-oriented
5 services in the least restrictive and most integrated settings for each stage of an
6 individual's recovery.
7 (4) Two key elements of Act 79 were never realized: a 24-hour peer-run
8 warm line and eight residential recovery beds. Other elements of Act 79 were
9 fully implemented.
10 (5) Since Tropical Storm Irene flooded the Vermont State Hospital,
11 Vermont has experienced a dramatic increase in the number of individuals in
12 mental health distress experiencing long waits in emergency departments for
13 inpatient hospital beds. Currently, hospitals average 90 percent occupancy,
14 while crisis beds average just under 70 percent occupancy, the latter largely
15 due to understaffing. Issues related to hospital discharge include an inadequate
16 staffing in community programs, insufficient community programs, and
17 inadequate supply of housing.
18 (6) Individuals presenting in emergency departments reporting acute
19 psychiatric distress often remain in that setting for many hours or days under
20 the supervision of hospital staff, peers, crisis workers, or law enforcement
21 officers, until a bed in a psychiatric inpatient unit becomes available. Many of

1 these individuals do not have access to a psychiatric care provider, and the
2 emergency department does not provide a therapeutic environment. Due to
3 these conditions, some individuals experience trauma and worsening
4 symptoms while waiting for an appropriate level of care. Hospitals are also
5 strained and report that their staff is demoralized that they cannot care
6 adequately for psychiatric patients and consequently there is a rise in turnover
7 rates. Many hospitals are investing in special rooms for psychiatric
8 emergencies and hiring mental health technicians to work in the emergency
9 departments.
10 (7) Traumatic waits in emergency departments for children and
11 adolescents in crisis are increasing, and there are limited resources for crisis
12 support, hospital diversion, and inpatient care for children and adolescents in
13 Vermont.
14 (8) Addressing mental health care needs within the health care system in
15 Vermont requires appropriate data and analysis, but simultaneously the
16 urgency created by those individuals suffering under existing circumstances
17 must be recognized.
18 (9) Research has shown that there are specific factors associated with
19 long waits, including homelessness, interhospital transfer, public insurance,
20 use of sitters or restraint, age, comorbid medical conditions, alcohol and
21 substance use, diagnoses of autism, intellectual disability, developmental

1 delay, and suicidal ideation. Data have not been captured in Vermont to
2 identify factors that may be associated with longer wait times and that could
3 help pinpoint solutions.
4 (10) Vermonters in the custody of the Commissioner of Corrections
5 often do not have access to appropriate crisis or routine mental health supports
6 or to inpatient care when needed, and are often held in correctional facilities
7 after being referred for inpatient care due to the lack of access to inpatient
8 beds. The General Assembly is working to address this aspect of the crisis
9 through parallel legislation during the 2017–2018 biennium.
10 (11) Care provided by the designated agencies is the cornerstone upon
11 which the public mental health system balances. However, many Vermonters
12 seeking help for psychiatric symptoms at emergency departments are not
13 clients of the designated or specialized service agencies and are meeting with
14 the crisis response team for the first time. Some of the individuals presenting
15 in emergency departments are able to be assessed, stabilized, and discharged to
16 return home or to supportive programming provided by the designated and
17 specialized service agencies.
18 (12) Act 79 specified that it was the intent of the General Assembly that
19 "the [A]gency of [H]uman [S]ervices fully integrate all mental health services
20 with all substance abuse, public health, and health care reform initiatives,
21 consistent with the goals of parity." However, reimbursement rates for crisis,

1 outpatient, and inpatient care are often segregated from health care payment
2 structures and payment reform.
3 (13) There is a shortage of psychiatric care professionals, both
4 nationally and statewide. Psychiatrists working in Vermont have testified that
5 they are distressed that individuals with psychiatric conditions remain for
6 lengthy periods of time in emergency departments and that there is an overall
7 lack of health care parity between mental conditions and other health
8 conditions.
9 (14) In 2007, a study commissioned by the Agency of Human Services
10 substantiated that designated and specialized service agencies face challenges
11 in meeting the demand for services at current funding levels. It further found
12 that keeping pace with current inflation trends, while maintaining existing
13 caseload levels, required annual funding increases of eight percent across all
14 payers to address unmet demand. Since that time, cost of living adjustments
15 appropriated to designated and specialized service agencies have been raised
16 by less than one percent annually.
17 (15) Designated and specialized service agencies are required by statute
18 to provide a broad array of services, including many mandated services that are
19 not fully funded.
20 (16) Evidence regarding the link between social determinants and
21 healthy families has become increasingly clear in recent years. Improving an

1 individual's trajectory requires addressing the needs of children and
2 adolescents in the context of their family and support networks. This means
3 Vermont must work within a multi-generational framework. While these
4 findings primarily focus on the highest acuity individuals within the adult
5 system, it is important also to focus on children's and adolescents' mental
6 health. Social determinants, when addressed, can improve an individual's
7 health; therefore housing, employment, food security, and natural support must
8 be considered as part of this work as well.
9 (17) Before moving ahead with changes to improve mental health care
10 and to achieve its integration with comprehensive health care reform, an
11 analysis is necessary to take stock of how it is functioning and what resources
12 are necessary for evidence-based or best practice and cost-efficient
13 improvements that best meet the mental health needs of Vermont children,
14 adolescents, and adults in their recovery.
15 (18) It is essential to the development of both short- and long-term
16 improvements to mental health care for Vermonters that a common vision be
17 established regarding how integrated, recovery-oriented services will emerge
18 as part of a comprehensive and holistic health care system.

1 Sec. 2. LEGISLATIVE INTENT

2 It is the intent of the General Assembly to continue to work toward a system
3 of health care that is fully inclusive of access to mental health care and meets
4 the principles adopted in 18 V.S.A. § 7251, including:

5 (1) The State of Vermont shall meet the needs of individuals with
6 mental health conditions, including the needs of individuals in the custody of
7 the Commissioner of Corrections, and the State's mental health system shall
8 reflect excellence, best practices, and the highest standards of care.

9 (2) Long-term planning shall look beyond the foreseeable future and
10 present needs of the mental health community. Programs shall be designed to
11 be responsive to changes over time in levels and types of needs, service
12 delivery practices, and sources of funding.

13 (3) Vermont's mental health system shall provide a coordinated
14 continuum of care by the Departments of Mental Health and of Corrections,
15 designated hospitals, designated agencies, and community and peer partners to
16 ensure that individuals with mental health conditions receive care in the most
17 integrated and least restrictive settings available. Individuals' treatment
18 choices shall be honored to the extent possible.

19 (4) The mental health system shall be integrated into the overall health
20 care system.

1 (5) Vermont's mental health system shall be geographically and
2 financially accessible. Resources shall be distributed based on demographics
3 and geography to increase the likelihood of treatment as close to the patient's
4 home as possible. All ranges of services shall be available to individuals who
5 need them, regardless of individuals' ability to pay.
6 (6) The State's mental health system shall ensure that the legal rights of
7 individuals with mental health conditions are protected.
8 (7) Oversight and accountability shall be built into all aspects of the
9 mental health system.
10 (8) Vermont's mental health system shall be adequately funded and
11 financially sustainable to the same degree as other health services.
12 (9) Individuals with a psychiatric disability or mental condition who are
13 in the custody or temporary custody of the Commissioner of Mental Health
14 and who receive treatment in an acute inpatient hospital unit, intensive
15 residential recovery facility, or a secure residential recovery facility shall be
16 afforded rights and protections that reflect evidence-based best practices aimed
17 at reducing the use of emergency involuntary procedures.
18 * * * Analysis, Action Plan, and Long-Term Vision Evaluation * * *
19 Sec. 3. ANALYSIS, ACTION PLAN, AND LONG-TERM VISION FOR
20 THE PROVISION OF MENTAL HEALTH CARE WITHIN THE
21 HEALTH CARE SYSTEM

1 (a) In order to address the present crisis that emergency departments are
2 experiencing in treating an individual who presents with symptoms of a mental
3 health crisis, and in recognition that this crisis is a symptom of larger
4 systematic shortcomings in the provision of mental health services statewide,
5 the General Assembly seeks an analysis and action plan from the Secretary of
6 Human Services in accordance with the following specifications:
7 (1) On or before December 15, 2017, the Secretary of Human Services,
8 in collaboration with the Commissioner of Mental Health, the Green Mountain
9 Care Board, providers, and persons who are affected by current services, shall
10 submit an action plan with recommendations and legislative proposals to the
11 Senate Committee on Health and Welfare and to the House Committees on
12 Health Care and on Human Services that shall be informed by an analysis of
13 specific issues described in this section and Sec. 4 of this act. The analysis
14 shall be conducted in conjunction with the planned updates to the Health
15 Resource Allocation Plan (HRAP) described in 18 V.S.A. § 9405, of which the
16 mental health and health care integration components shall be prioritized.
17 With regard to children, adolescents, and adults, the analysis and action plan
18 shall:
19 (A) specify steps to develop a common, long-term, statewide vision
20 of how integrated, recovery-oriented services shall emerge as part of a
21 comprehensive and holistic health care system;

1 (B) identify data that are not currently gathered, and that are
2 necessary for current and future planning, long-term evaluation of the system,
3 and for quality measurements, including identification of any data requiring
4 legislation to ensure their availability;
5 (C) identify the causes underlying increased referrals and self-
6 referrals for emergency services;
7 (D) identify gaps in services that affect the ability of individuals to
8 access emergency psychiatric care;
9 (E) determine whether appropriate types of care are being made
10 available as services in Vermont, including intensive and other outpatient
11 services and services for transition age youths;
12 (F) determine the availability and regional accessibility of voluntary
13 and involuntary hospital admissions, emergency departments, intensive
14 residential recovery facilities, secure residential recovery facilities, crisis beds
15 and other diversion capacities, crisis intervention services, peer respite and
16 support services, and stable housing;
17 (G) identify barriers to efficient, medically necessary, recovery-
18 oriented, patient care at levels of supports that are least restrictive and most
19 integrated, and opportunities for improvement;
20 (H) incorporate existing information from research and from
21 established quality metrics regarding emergency department wait times;

1 (I) incorporate anticipated demographic trends, the impact of the
2 opiate crisis, and data that indicate short- and long-term trends; and
3 (J) identify the levels of resources necessary to attract and retain
4 qualified staff to meet identified outcomes required of designated and
5 specialized service agencies and specify a timeline for achieving those levels
6 of support.
7 (2) On or before September 1, 2017, the Secretary shall submit a status
8 report to the Senate Committee on Health and Welfare and to the House
9 Committees on Health Care and on Human Services describing the progress
10 made in completing the analysis required pursuant to this subsection and
11 producing a corresponding action plan. The status report shall include any
12 immediate action steps that the Agency was able to take to address the
13 emergency department crisis that did not require additional resources or
14 legislation.
15 (b)(1) Data collected to inform the analysis and action plan regarding
16 emergency services for persons with psychiatric symptoms or complaints,
17 patients who are seeking voluntary assistance, and those under the temporary
18 custody of the Commissioner shall include at least:
19 (A) the circumstances under which and reasons why a person is being
20 referred or self-referred to emergency services;
21 (B) reports on the use of restraints, including chemical restraints;

1 (C) any criminal charges filed against an individual during
2 emergency department waits;
3 (D) measurements shown by research to affect length of waits, such
4 as homelessness, the need for an interhospital transfer, transportation
5 arrangements, health insurance status, age, comorbid conditions, prior health
6 history, and response time for crisis services and for the first certification of an
7 emergency evaluation pursuant to 18 V.S.A. § 7504; and
8 (E) rates at which persons brought to emergency departments for
9 emergency examinations pursuant to 18 V.S.A. §§ 7504 and 7505 are found
10 not to be in need of inpatient hospitalization.
11 (2) Data to otherwise inform the action plan and preliminary analysis
12 shall include short- and long-term trends in inpatient length of stay and
13 readmission rates.
14 (3) Data for persons under 18 years of age shall be collected and
15 analyzed separately.
16 (c) On or before January 15, 2019, the Secretary shall submit a
17 comprehensive evaluation of the overarching structure for the delivery of
18 mental health services within a sustainable, holistic health care system in
19 Vermont to the Senate Committee on Health and Welfare and to the House
20 Committees on Health Care and on Human Services, including:

1 (1) whether the current structure is succeeding in serving Vermonters
2 with mental health needs and meeting the goals of access, quality, and
3 integration of services;
4 (2) whether quality and access to mental health services are equitable
5 throughout Vermont;
6 (3) whether the current structure advances the long-term vision of an
7 integrated, holistic health care system;
8 (4) how the designated and specialized service agency structure
9 contributes to the realization of that long-term vision;
10 (5) how mental health care is being fully integrated into health care
11 payment reform; and
12 (6) any recommendations for structural changes to the mental health
13 system that would assist in achieving the vision of an integrated, holistic health
14 care system.
15 Sec. 4. COMPONENTS OF ANALYSIS, ACTION PLAN, AND LONG-
16 TERM VISION EVALUATION
17 The analysis, action plan, and long-term vision evaluation required by Sec.
18 3 of this act shall address the following:
19 (1) Care coordination. The analysis, action plan, and long-term vision
20 evaluation shall address the potential benefits and costs of developing regional
21 navigation and resource centers for referrals from primary care, hospital

1 emergency departments, inpatient psychiatric units, correctional facilities, and
2 community providers, including the designated and specialized service
3 agencies, private counseling services, and peer-run services. The goal of
4 regional navigation and resource centers is to foster improved access to
5 efficient, medically necessary, and recovery-oriented patient care at levels of
6 support that are least restrictive and most integrated for individuals with mental
7 health conditions, substance use disorders, or co-occurring conditions.
8 Consideration of regional navigation and resource centers shall include
9 consideration of other coordination models identified during the preliminary
10 analysis, including models that address the goal of an integrated health
11 system.
12 (2) Accountability. The analysis, action plan, and long-term vision
13 evaluation shall address the effectiveness of the Department's care
14 coordination team in providing access to and adequate accountability for
15 coordination and collaboration among hospitals and community partners for
16 transition and ongoing care, including the judicial and corrections systems. An
17 assessment of accountability shall include an evaluation of potential
18 discrimination in hospital admissions at different levels of care and the extent
19 to which individuals are served by their medical homes.
20 (3)(A) Crisis diversion evaluation. The analysis, action plan, and long-
21 term vision evaluation shall evaluate:

1 (i) existing and potential new models, including the 23-hour bed
2 model, that prevent or divert individuals from the need to access an emergency
3 department;
4 (ii) models for children, adolescents, and adults; and
5 (iii) whether existing programs need to be expanded, enhanced, or
6 reconfigured, and whether additional capacity is needed.
7 (B) Diversion models used for patient assessment and stabilization,
8 involuntary holds, diversion from emergency departments, and holds while
9 appropriate discharge plans are determined shall be considered, including the
10 extent to which they address psychiatric oversight, nursing oversight and
11 coordination, peer support, security, and geographic access. If the preliminary
12 analysis identifies a need for or the benefits of additional, enhanced, expanded,
13 or reconfigured models, the action plan shall include preliminary steps
14 necessary to identify licensing needs, implementation, and ongoing costs.
15 (4) Implementation of Act 79. The analysis, action plan, and long-term
16 vision evaluation, in coordination with the work completed by the Department
17 of Mental Health for its annual report pursuant to 18 V.S.A. § 7504, shall
18 address whether those components of the system envisioned in 2012 Acts and
19 Resolves No. 79 that have not been fully implemented remain necessary and
20 whether those components that have been implemented are adequate to meet
21 the needs identified in the preliminary analysis. Priority shall be given to

1 determining whether there is a need to fund fully the 24-hour warm line and
2 eight unutilized intensive residential recovery facility beds and whether other
3 models of supported housing are necessary. If implementation or expansion of
4 these components is deemed necessary in the preliminary analysis, the action
5 plan shall identify the initial steps needed to plan, design, and fund the
6 recommended implementation or expansion.
7 (5) Mental health access parity. The analysis, action plan, and long-
8 term vision evaluation shall evaluate opportunities for and remove barriers to
9 implementing parity in the manner that individuals presenting at hospitals are
10 received, regardless of whether for a psychiatric or other health care condition.
11 The evaluation shall examine: existing processes to screen and triage health
12 emergencies; transfer and disposition planning; stabilization and admission;
13 and criteria for transfer to specialized or long-term care services.
14 (6) Geriatric psychiatric support services, residential care, or skilled
15 nursing unit or facility. The analysis, action plan, and long-term vision
16 evaluation shall evaluate the extent to which additional support services are
17 needed for geriatric patients in order to prevent hospital admissions or to
18 facilitate discharges from inpatient settings, including community-based
19 services, enhanced residential care services, enhanced supports within skilled
20 nursing units or facilities, or new units or facilities. If the preliminary analysis
21 concludes that the situation warrants more home- and community-based

1 services, a geriatric nursing home unit or facility, or any combination thereof,
2 the action plan shall include a proposal for the initial funding phases and, if
3 appropriate, siting and design, for one or more units or facilities with a focus
4 on the clinical best practices for these patient populations. The action plan and
5 preliminary analysis shall also include means for improving coordination and
6 shared care management between Choices for Care and the designated and
7 specialized service agencies.
8 (7) Forensic psychiatric support services or residential care. The
9 analysis, action plan, and long-term vision evaluation shall evaluate the extent
10 to which additional services or facilities are needed for forensic patients in
11 order to enable appropriate access to inpatient care, prevent hospital
12 admissions, or facilitate discharges from inpatient settings. These services
13 may include community-based services or enhanced residential care services.
14 The action plan and preliminary analysis shall be completed in coordination
15 with other relevant assessments regarding access to mental health care for
16 persons in the custody of the Commissioner of Corrections as required by the
17 General Assembly during the first year of the 2017–2018 biennium.
18 (8) Units or facilities for use as nursing or residential homes or
19 supportive housing. To the extent that the analysis indicates a need for
20 additional units or facilities, it shall require consultation with the
21 Commissioner of Buildings and General Services to determine whether there

1 are any units or facilities that the State could be utilized for a geriatric skilled
2 nursing or forensic psychiatric facility, an additional intensive residential
3 recovery facility, an expanded secure residential recovery facility, or
4 supportive housing.
5 (9) Designated and specialized service agencies. The analysis, action
6 plan, and long-term vision evaluation shall estimate the levels of funding
7 necessary to sustain the designated and specialized service agencies'
8 workforce; enable the designated and specialized service agencies to meet their
9 statutorily mandated responsibilities and required outcomes; identify the
10 required outcomes; and establish recommended levels of increased funding for
11 inclusion in the fiscal year 2019 budget.
12 Sec. 5. INVOLUNTARY TREATMENT AND MEDICATION REVIEW
13 (a) On or before December 15, 2017, the Secretary of Human Services, in
14 collaboration with the Commissioner of Mental Health and the Chief Superior
15 Judge, shall analyze and submit a report to the Senate Committee on Health
16 and Welfare to the House Committee on Health Care regarding the role that
17 involuntary treatment and psychiatric medication play in inpatient emergency
18 department wait times. The analysis shall examine gaps and shortcomings in
19 the mental health system, including the adequacy of housing and community
20 resources available to divert patients from involuntary hospitalization;
21 treatment modalities, including involuntary medication and non-medication

1 alternatives available to address the needs of patients in psychiatric crises; and
2 other characteristics of the mental health system that contribute to prolonged
3 stays in hospital emergency departments and inpatient psychiatric units. The
4 analysis shall also examine the interplay between the rights of staff and
5 patients' rights and the use of involuntary treatment and medication.
6 Additionally, to provide the General Assembly with a wide variety of options,
7 the analysis shall examine the following, including the legal implications, the
8 rationale or disincentives, and a cost-benefit analysis for each:
9 (1) a statutory directive to the Department of Mental Health to prioritize
10 the restoration of competency where possible for all forensic patients
11 committed to the care of the Commissioner; and
12 (2) enabling applications for involuntary treatment and applications for
13 involuntary medication to be filed simultaneously or at any point that a
14 psychiatrist believes joint filing is necessary for the restoration of the
15 individual's competency.
16 (b) The Secretary of Human Services, shall submit a report to the Senate
17 Committee on Health and Welfare, the House Committee on Health Care, and
18 the Chief Superior Judge that identifies areas of concern regarding the efficient
19 and expeditious resolution of cases filed pursuant to 18 V.S.A. chapter 181,
20 including any issues relating to changes of venue, scheduling of hearings,
21 judicial caseloads, the causes for any delays in the process of scheduling and

1 resolving cases, and any proposals to improve the efficient resolution of cases
2 without reducing the due process afforded to patients. The report shall include
3 data in support of identified concerns.
4 (c)(1) On or before January 15, 2018, Vermont Legal Aid, Disability
5 Rights Vermont, and Vermont Psychiatric Survivors shall have the opportunity
6 to submit an addendum addressing the Secretary's analysis and report
7 completed pursuant to subsections (a) and (b) of this section.
8 (2) On or before January 15, 2018, the Chief Superior Judge shall have
9 the opportunity to submit an addendum addressing the Department of Mental
10 Health's report completed pursuant to subsection (b) of this section.
11 (d)(1) On or before November 15, 2017, the Department shall issue a
12 request for information for a longitudinal study comparing the outcomes of
13 patients who received court-ordered medications while hospitalized with those
14 of patients who did not receive court-order medication while hospitalized,
15 including both patients who voluntarily received medication and those who
16 received no medication, for a period from 1998 to the present. The request for
17 information shall specify that the study examine the following measures:
18 (A) the length of an individual's involuntary hospitalization
19 (B) the time spent by an individual in inpatient and outpatient
20 settings;

1 (C) the number of an individual's hospital admissions, including both
2 voluntary and involuntary admissions;
3 (D) the number of and length of time of an individual's residential
4 placements;
5 (E) an individual's success in different types of residential settings;
6 (F) any employment or other vocational and educational activities
7 after hospital discharge;
8 (G) any criminal charges after hospital discharge; and
9 (H) other parameters determined in consultation with representatives
10 of inpatient and community treatment providers and advocates for the rights of
11 psychiatric patients.
12 (2) Request for information proposals shall include estimated costs, time
13 frames for conducting the work, and any other necessary information.
14 * * * Payment Structures * * *
15 Sec. 6. INTEGRATION OF PAYMENTS; ACCOUNTABLE CARE
16 ORGANIZATIONS
17 (a) Pursuant to 18 V.S.A. § 9382, the Green Mountain Care Board shall
18 review an accountable care organization's (ACO) model of care and
19 integration with community providers, including designated and specialized
20 service agencies, regarding how the model of care promotes seamless
21 coordination across the care continuum, business or operational relationships

1 between the entities, and any proposed investments or expansions to
2 community-based providers. The purpose of this review is to ensure progress
3 toward and accountability to the population health measures related to mental
4 health and substance use disorder contained in the All Payer ACO Model
5 Agreement.
6 (b) In the Board's annual report due on January 15, 2018, the Green
7 Mountain Care Board shall include a summary of information relating to
8 integration with community providers, as described in subsection (a) of this
9 section, received in the first ACO budget review under 18 V.S.A. § 9382.
10 (c) On or before December 31, 2020, the Agency of Human Services, in
11 collaboration with the Green Mountain Care Board, shall provide a copy of the
12 report required by Section 11 of the All-Payer Model Accountable Care
13 Organization Model Agreement, which outlines a plan for including the
14 financing and delivery of community-based providers in delivery system
15 reform, to the Senate Committee on Health and Welfare and the House
16 Committee on Health Care.
17 Sec. 7. PAYMENTS TO THE DESIGNATED AND SPECIALIZED
18 SERVICE AGENCIES
19 The Secretary of Human Services, in collaboration with the Commissioners
20 of Mental Health and of Disabilities, Aging, and Independent Living;
21 providers; and persons who are affected by current services, shall develop a

1 plan to integrate multiple sources of payments for mental and substance abuse
2 services to the designated and specialized service agencies. In a manner
3 consistent with Sec. 11 of this act, the plan shall implement a Global Funding
4 model as a successor to the analysis and work conducted under the Medicaid
5 Pathways and other work undertaken regarding mental health in health care
6 reform. It shall increase efficiency and reduce the administrative burden. On
7 or before January 1, 2018, the Secretary shall submit the plan and any related
8 legislative proposals to the Senate Committee on Health and Welfare and the
9 House Committees on Health Care and on Human Services.
10 Sec. 8. ALIGNMENT OF FUNDING WITHIN THE AGENCY OF HUMAN
11 SERVICES
12 For the purpose of creating a more transparent system of public funding for
13 mental health services, the Agency of Human Services shall continue with
14 budget development processes enacted in legislation during the first year of the
15 2015–2016 biennium that unify payment for services, policies, and utilization
16 review of services within an appropriate department consistent with Secs. 6
17 and 7 of this act.
18 * * * Workforce Development * * *
19 Sec. 9. MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND
20 SUBSTANCE USE DISORDER WORKFORCE STUDY
21 COMMITTEE

1 (a) Creation. There is created the Mental Health, Developmental
2 Disabilities, and Substance Use Disorder Workforce Study Committee to
3 examine best practices for training, recruiting, and retaining health care
4 providers and other service providers in Vermont, particularly with regard to
5 the fields of mental health, developmental disabilities, and substance use
6 disorders. It is the goal of the General Assembly to enhance program capacity
7 in the State to address ongoing workforce shortages.
8 (b) Membership. The Committee shall be composed of the following
9 members:
10 (1) the Secretary of Human Services or designee, who shall serve as the
11 Chair;
12 (2) the Commissioner of Labor or designee;
13 (3) the Commissioner of Mental Health or designee;
14 (4) the Commissioner of Disabilities, Aging, and Independent Living or
15 designee;
16 (5) the Commissioner of Health or designee;
17 (6) a representative of the Vermont State Colleges;
18 (7) a representative of the Governor's Health Care Workforce Work
19 Group created by Executive Order 07-13;
20 (8) a representative of persons affected by current services;

1 (9) a representative of the families of person affected by current
2 services;
3 (10) a representative of the designated and specialized service agencies
4 appointed by Vermont Care Partners;
5 (11) the Director of Substance Abuse Prevention;
6 (12) a representative appointed by the Area Health Education
7 Centers; and
8 (13) any other appropriate individuals by invitation of the Chair.
9 (c) Powers and duties. The Committee shall consider and weigh the
10 effectiveness of loan repayment, tax abatement, long-term employment
11 agreements, funded training models, internships, rotations, and any other
12 evidence-based training, recruitment, and retention tools available for the
13 purpose of attracting and retaining qualified health care providers in the State,
14 particularly with regard to the fields of mental health, developmental
15 disabilities, and substance use disorders.
16 (d) Assistance. The Committee shall have the administrative, technical,
17 and legal assistance of the Agency of Human Services.
18 (e) Report. On or before December 15, 2017, the Committee shall submit a
19 report to the Senate Committee on Health and Welfare and the House
20 Committees on Health Care and on Human Services regarding the results of its
21 examination, including any legislative proposals for both long-term and

1 immediate steps the State may take to attract and retain more health care
2 providers in Vermont.
3 (f) Meetings.
4 (1) The Secretary of Human Services shall call the first meeting of the
5 Committee to occur on or before July 1, 2017.
6 (2) A majority of the membership shall constitute a quorum.
7 (3) The Committee shall cease to exist on December 31, 2017.
8 Sec. 10. OFFICE OF PROFESSIONAL REGULATION; INTERSTATE
9 COMPACTS
10 The Director of Professional Regulation shall engage other states in a
11 discussion of the creation of national standards for coordinating the regulation
12 and licensing of mental health professionals, as defined in 18 V.S.A. § 7101,
13 for the purposes of licensure reciprocity and greater interstate mobility of that
14 workforce. On or before September 1, 2017, the Director shall report to the
15 Senate Committee on Health and Welfare and the House Committee on Health
16 Care regarding the results of his or her efforts and recommendations for
17 legislative action.

1 * * * Designated and Specialized Service Agencies * * *

2 Sec. 11. 18 V.S.A. § 8914 is added to read:

3 § 8914. RATES OF PAYMENTS TO DESIGNATED AND SPECIALIZED

4 SERVICE AGENCIES

5 (a) The Secretary of Human Services shall have sole responsibility for
6 establishing the Departments of Health, of Mental Health, and of Disabilities,
7 Aging, and Independent Living's rates of payments for designated and
8 specialized service agencies and the Alcohol and Drug Abuse Program's
9 preferred providers that are reasonable and adequate to meet the costs of
10 achieving the required outcomes for designated populations. When
11 establishing rates of payment for designated and specialized service agencies,
12 the Secretary shall adjust rates to take into account factors that include:

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

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

18 (b) When establishing rates of payment for designated and specialized
19 service agencies and the Alcohol and Drug Abuse Program's preferred
20 providers, the Secretary may consider geographic differences in wages,
21 benefits, housing, and real estate costs in each region of the State.

1 Sec. 12. HEALTH INSURANCE; DESIGNATED AND SPECIALIZED
2 SERVICE AGENCY EMPLOYEES
3 On or before September 1, 2017, the Commissioner of Human Resources
4 shall consult with Blue Cross and Blue Shield of Vermont and Vermont Care
5 Partners regarding the operational feasibility of including the designated and
6 specialized service agencies in the State employees' health benefit plan and
7 submit any findings and relevant recommendations for legislative action to the
8 Senate Committees on Health and Welfare, on Government Operations, and on
9 Finance and the House Committees on Health Care and on Government
10 Operations.
11 * * * Effective Date * * *
12 Sec. 13. EFFECTIVE DATE
13 This act shall take effect on passage.
14 (Committee vote: ___________)
15 _______________________
16 Representative ___________
17 FOR THE COMMITTEE