TO THE HOUSE OF REPRESENTATIVES:

The Committee on Health Care to which was referred Senate Bill No. 133 entitled "An act relating to examining mental health care and care coordination" respectfully reports that it has considered the same and recommends that the House propose to the Senate that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

* * * Findings and Legislative Intent * * *

Sec. 1. FINDINGS

The General Assembly finds that:

(1) The State's mental health system has changed during the past ten years, with regard to both policy and the structural components of the system.

(2) The State's adult mental health inpatient system was disrupted after Tropical Storm Irene flooded the Vermont State Hospital in 2011. The General Assembly, in 2012 Acts and Resolves No. 79, responded by designing a system "to provide flexible and recovery-oriented treatment opportunities and to ensure that the mental health needs of Vermonters are served."

(3) Elements of Act 79 included the addition of over 50 long- and short-term residential beds to the State's mental health system, all of which are operated by the designated and specialized service agencies, increased peer support services, and replacement inpatient beds. It also was intended to

strengthen existing care coordination within the Department of Mental Health to assist community providers and hospitals in the development of a system that provided rapid access to each level of support within the continuum of care as needed to ensure appropriate, high-quality, and recovery-oriented services in the least restrictive and most integrated settings for each stage of an individual's recovery.

(4) Two key elements of Act 79 were never realized: a 24-hour peer-run warm line and eight residential recovery beds. Other elements of Act 79 were fully implemented.

(5) Since Tropical Storm Irene flooded the Vermont State Hospital, Vermonters have experienced dramatic increases in the number of individuals in mental health distress experiencing long waits in emergency departments for inpatient hospital beds. Currently, hospitals average 90 percent occupancy, while crisis beds average just under 70 percent occupancy, the latter largely due to understaffing. Issues related to hospital discharge include an inadequate staffing in community programs, insufficient community programs, and inadequate supply of housing.

(6) Individuals presenting in emergency departments reporting acute psychiatric distress often remain in that setting for many hours or days under the supervision of hospital staff, peers, crisis workers, or law enforcement officers, until a bed in a psychiatric inpatient unit becomes available. Many of

these individuals do not have access to a psychiatric care provider, and the emergency department does not provide a therapeutic environment. Due to these conditions some individuals experience trauma and worsening symptoms while waiting for an appropriate level of care. Hospitals are also strained and report that their staff is demoralized that they cannot care adequately for psychiatric patients and consequently there is a rise in turnover rates. Many hospitals are investing in special rooms for psychiatric emergencies and hiring mental health technicians to work in the emergency departments.

(7) Traumatic waits in emergency departments for children and adolescents in crisis are increasing, and there are limited resources for crisis support, hospital diversion, and inpatient care for children and adolescents in Vermont.

(8) Addressing mental health care needs within the health care system in Vermont requires appropriate data and analysis, but simultaneously must recognize the urgency created by those individuals suffering under existing circumstances.

(9) Research has shown that there are specific factors associated with long waits, including homelessness, interhospital transfer, public insurance, use of sitters or restraint, age, comorbid medical conditions, alcohol and substance use, diagnoses of autism, intellectual disability, developmental delay, and suicidal ideation. Data have not been captured in Vermont to

identify factors that may be associated with longer wait times and that could help pinpoint solutions.

(10) Vermonters in the custody of the Commissioner of Corrections often do not have access to appropriate crisis or routine mental health supports or to inpatient care when needed, and are often held in correctional facilities due to the lack of access to inpatient beds. The General Assembly is working to address this aspect of the crisis through parallel legislation during the 2017–2018 biennium.

(11) Care provided by the designated agencies is the cornerstone upon which the public mental health system balances. Vermonters seeking help for psychiatric symptoms at emergency departments are not clients of the designated or specialized service agencies and are meeting with the crisis response team for the first time. Some of the individuals presenting in emergency departments are able to be assessed, stabilized, and discharged to return home or to supportive programming provided by the designated and specialized service agencies.

(12) Act 79 specified that it was the intent of the General Assembly that " the [A]gency of [H]uman [S]ervices fully integrate all mental health services with all substance abuse, public health, and health care reform initiatives, consistent with the goals of parity." However, reimbursement rates for crisis,

outpatient, and inpatient care are often segregated from health care payment structures and payment reform.

(13) There is a shortage of psychiatric care professionals, both nationally and statewide. Psychiatrists working in Vermont have testified that they are distressed that individuals with psychiatric conditions remain for lengthy periods of time in emergency departments and that there is an overall lack of health care parity between mental conditions and other health conditions.

(14) In 2007, a study commissioned by the Agency of Human Services substantiated that designated and specialized service agencies face challenges in meeting the demand for services at current funding levels. It further found that keeping pace with current inflation trends, while maintaining existing caseload levels, required annual funding increases of eight percent across all payers to address unmet demand. Since that time, cost of living adjustments appropriated to designated and specialized service agencies have been raised by less than one percent annually.

(15) Designated and specialized service agencies are required by statute to provide a broad array of services, including many mandated services that are not fully funded.

(16) Evidence regarding the link between social determinants and healthy families has become increasingly clear in recent years. Improving an

individual's trajectory requires addressing the needs of children and adolescents in the context of their family and support networks. This means Vermont must work within a multi-generational framework. While these findings primarily focus on the highest acuity individuals within the adult system, it is important also to focus on children's and adolescents' mental health. Social determinants, when addressed, can improve an individual's health; therefore housing, employment, food security, and natural support must be considered as part of this work as well.

(17) Before moving ahead with changes to improve mental health care and to achieve its integration with comprehensive health care reform, an analysis is necessary to take stock of how it is functioning and what resources are necessary for evidence-based or best practice and cost-efficient improvements that best meet the mental health needs of Vermont children, adolescents, and adults in their recovery.

(18) It is essential to the development of both short- and long-term improvements to mental health care for Vermonters that a common vision be established regarding how integrated, recovery-oriented services will emerge as part of a comprehensive and holistic health care system.

Sec. 2. LEGISLATIVE INTENT

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

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

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

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

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

(5) Vermont's mental health system shall be geographically and financially accessible. Resources shall be distributed based on demographics and geography to increase the likelihood of treatment as close to the patient's home as possible. All ranges of services shall be available to individuals who need them, regardless of individuals' ability to pay.

(6) The State's mental health system shall ensure that the legal rights of individuals with mental health conditions are protected.

(7) Oversight and accountability shall be built into all aspects of the mental health system.

(8) Vermont's mental health system shall be adequately funded and financially sustainable to the same degree as other health services.

(9) Individuals with a psychiatric disability or mental condition who are in the custody or temporary custody of the Commissioner of Mental Health and who receive treatment in an acute inpatient hospital unit, intensive residential recovery facility, or a secure residential recovery facility shall be afforded rights and protections that reflect evidence-based best practices aimed at reducing the use of emergency involuntary procedures.

* * * Analysis, Action Plan, and Long-Term Vision Evaluation* * *

Sec. 3. ANALYSIS, ACTION PLAN, AND LONG-TERM VISION FOR THE PROVISION OF MENTAL HEALTH CARE WITHIN THE HEALTH CARE SYSTEM

(a) In order to address the present crisis that emergency departments are experiencing in treating an individual who presents with symptoms of a mental health crisis, and in recognition that this crisis is a symptom of larger systematic shortcomings in the provision of mental health services statewide, the General Assembly seeks an analysis and action plan from the Secretary of Human Services in accordance with the following specifications:

(1) On or before December 15, 2017, the Secretary of Human Services, in collaboration with the Commissioner of Mental Health, the Green Mountain Care Board, and persons who are affected by current services, shall submit an action plan with recommendations and legislative proposals to the Senate Committee on Health and Welfare and to the House Committees on Health Care and on Human Services that shall be informed by an analysis of specific issues described in this section and Sec. 4 of this act. The analysis shall be conducted in conjunction with the planned updates to the Health Resource Allocation Plan (HRAP) described in 18 V.S.A. § 9405, of which the mental health and health care integration components shall be prioritized. With regard to children, adolescents, and adults, the analysis and action plan shall:

(A) specify steps to develop a common, long-term, statewide vision of how integrated, recovery-oriented services shall emerge as part of a comprehensive and holistic health care system;

(B) identify data that are not currently gathered, and which are necessary for current and future planning, long-term evaluation of the system, and for quality measurements, including identification of any data requiring legislation to ensure their availability;

(C) identify the causes underlying increased referrals and self-referrals for emergency services;

(D) identify gaps in services that affect the ability of individuals to access emergency psychiatric care;

(E) determine whether appropriate types of care are being made available as services in Vermont, including intensive and other outpatient services and services for transition age youths;

(F) determine the availability of voluntary and involuntary hospital admissions, emergency departments, intensive residential recovery facilities, secure residential recovery facilities, crisis beds and other diversion capacities, crisis intervention services, peer respite and support services, and stable housing;

(G) identify barriers to efficient, medically necessary, recovery-oriented, patient care at levels of supports that are least restrictive and most integrated, and opportunities for improvement;

(H) incorporate existing information from research and from established quality metrics regarding emergency department wait times; and

(I) incorporate anticipated demographic trends, the impact of the opiate crisis, and data that indicate short- and long-term trends.

(2) On or before September 1, 2017, the Secretary shall submit a status report to the Senate Committee on Health and Welfare and to the House Committees on Health Care and on Human Services describing the progress made in completing the analysis required pursuant to this subsection and producing a corresponding action plan. The status report shall include any immediate action steps that the Agency was able to take to address the emergency department crisis that did not require additional resources or legislation.

(b)(1) Data collected to inform the analysis and action plan regarding emergency services for persons with psychiatric symptoms or complaints, patients who are seeking voluntary assistance, and those under the temporary custody of the Commissioner shall include at least:

(A) the circumstances under which and reasons why a person is being referred or self-referred to emergency services;

(B) reports on the use of restraints, including chemical restraints;

(C) any criminal charges filed against an individual during emergency department waits;

(D) measurements shown by research to affect length of waits, such as homelessness, the need for an interhospital transfer, transportation

arrangements, health insurance status, age, comorbid conditions, prior health history, and response time for crisis services and for the first certification of an emergency evaluation pursuant to 18 V.S.A. § 7504; and

(E) rates at which persons brought to emergency departments for emergency examinations pursuant to 18 V.S.A. §§ 7504 and 7505 are found not to be in need of inpatient hospitalization.

(2) Data to otherwise inform the action plan and preliminary analysis shall include short- and long-term trends in inpatient length of stay and readmission rates.

(3) Data for persons under 18 years of age shall be collected and analyzed separately.

(c) On or before January 15, 2019, the Secretary shall submit a comprehensive evaluation of the overarching structure for the delivery of mental health services within a holistic health care system in Vermont to the Senate Committee on Health and Welfare and to the House Committees on Health Care and on Human Services, including:

(1) whether the current structure is succeeding in serving Vermonters with mental health needs and meeting the goals of access, quality, and integration of services;

(2) whether quality and access to mental health services are equitable throughout Vermont;

(3) whether the current structure advances the long-term vision of an integrated, holistic health care system;

(4) how the designated and specialized service agency structure contributes to the realization of that long-term vision;

(5) how mental health care is being fully integrated into health care payment reform; and

(6) any recommendations for structural changes to the mental health system that would assist in achieving the vision of an integrated, holistic health care system.

Sec. 4. COMPONENTS OF ANALYSIS, ACTION PLAN, AND LONG-TERM VISION EVALUATION

The analysis, action plan, and long-term vision evaluation required by Sec. 3 of this act shall address the following:

(1) *Care coordination.* The action plan and preliminary analysis shall address the potential benefits and costs of developing regional navigation and resource centers for referrals from primary care, hospital emergency departments, inpatient psychiatric units, correctional facilities, and community providers, including the designated and specialized service agencies, private counseling services, and peer-run services. The goal of regional navigation and resource centers is to foster improved access to efficient, medically necessary, and recovery-oriented patient care at levels of support that are least

restrictive and most integrated for individuals with mental health conditions, substance use disorders, or co-occurring conditions. Consideration of regional navigation and resource centers shall include consideration of other coordination models identified during the preliminary analysis, including models that address the goal of an integrated health system.

(2) *Accountability.* The action plan and preliminary analysis shall address the effectiveness of the Department's care coordination team in providing access to and adequate accountability for coordination and collaboration among hospitals and community partners for transition and ongoing care, including the judicial and corrections systems. An assessment of accountability shall include an evaluation of potential discrimination in hospital admissions at different levels of care and the extent to which individuals are served by their medical homes.

(3)(A) *Crisis diversion evaluation.* The action plan and preliminary analysis shall evaluate:

(i) existing and potential new models, including the 23-hour bed model, that prevent or divert individuals from the need to access an emergency department;

(ii) models for children, adolescents, and adults; and

(iii) whether existing programs need to be expanded, enhanced, or reconfigured, and whether additional capacity is needed.

(B) Diversion models used for patient assessment and stabilization, involuntary holds, diversion from emergency departments, and holds while appropriate discharge plans are determined shall be considered, including the extent to which they address psychiatric oversight, nursing oversight and coordination, peer support, security, and geographic access. If the preliminary analysis identifies a need for or the benefits of additional, enhanced, expanded, or reconfigured models, the action plan shall include preliminary steps necessary to identify licensing needs, implementation, and ongoing costs.

(4) *Implementation of Act 79.* The action plan and preliminary analysis, in coordination with the work completed by the Department of Mental Health for its annual report pursuant to 18 V.S.A. § 7504, shall address whether those components of the system envisioned in 2012 Acts and Resolves No. 79 that have not been fully implemented remain necessary and whether those components that have been implemented are adequate to meet the needs identified in the preliminary analysis. Priority shall be given to determining whether there is a need to fund fully the 24-hour warm line and eight unutilized intensive residential recovery facility beds and whether other models of supported housing are necessary. If implementation or expansion of these components is deemed necessary in the preliminary analysis, the action plan shall identify the initial steps needed to plan, design, and fund the recommended implementation or expansion.

(5) *Mental health access parity.* The action plan and preliminary analysis shall evaluate opportunities for and remove barriers to implementing parity in the manner that individuals presenting at hospitals are received, regardless of whether for a psychiatric or other health care condition. The evaluation shall examine: existing processes to screen and triage health emergencies; transfer and disposition planning; stabilization and admission; and criteria for transfer to specialized or long-term care services.

(6) *Geriatric psychiatric support services, residential care, or skilled nursing unit or facility.* The action plan and preliminary analysis shall evaluate the extent to which additional support services are needed for ~~a~~ geriatric patients in order to prevent hospital admissions or to facilitate discharges from inpatient settings, including community-based services, enhanced residential care services, enhanced supports within skilled nursing units or facilities, or new units or facilities. If the preliminary analysis concludes that the situation warrants more home- and community-based services, a geriatric nursing home unit or facility, or any combination thereof, the action plan shall include a proposal for the initial funding phases and, if appropriate, siting and design, for one or more units or facilities with a focus on the clinical best practices for these patient populations. The action plan and preliminary analysis shall also include means for improving coordination and shared care management between Choices for Care and the designated and specialized service agencies.

(7) *Forensic psychiatric support services or residential care.* The action plan and preliminary analysis shall evaluate the extent to which additional services or facilities are needed for forensic patients in order to enable appropriate access to inpatient care, prevent hospital admissions, or facilitate discharges from inpatient settings. These services may include community-based services or enhanced residential care services. The action plan and preliminary analysis shall be completed in coordination with other relevant assessments regarding access to mental health care for persons in the custody of the Commissioner of Corrections as required by the General Assembly during the first year of the 2017–2018 biennium.

(8) *Units or facilities for use as nursing or residential homes or supportive housing.* To the extent that the preliminary analysis indicates a need for additional units or facilities, it shall require consultation with the Commissioner of Buildings and General Services to determine whether there are any units or facilities that the State could utilize for a geriatric skilled nursing or forensic psychiatric facility, an additional intensive residential recovery facility, an expanded secure residential recovery facility, or supportive housing.

Sec. 5. INVOLUNTARY TREATMENT AND MEDICATION REVIEW

(a) The Secretary of Human Services, in collaboration with the Commissioner of Mental Health and the Chief Administrative Judge of the

Vermont Superior Courts, shall conduct an analysis of the role that involuntary treatment and psychiatric medication play in inpatient emergency department wait times. The analysis shall examine gaps and shortcomings in the mental health system, including the adequacy of housing and community resources available to divert patients from involuntary hospitalization; treatment modalities, including involuntary medication and non-medication alternatives available to address the needs of patients in psychiatric crises; and other characteristics of the mental health system that contribute to prolonged stays in hospital emergency departments and inpatient psychiatric units. The analysis shall also examine the interplay between the rights of staff and patients' rights and the use of involuntary treatment and medication. Additionally, to provide the General Assembly with a wide variety of options, the analysis shall examine the following, including the legal implications, the rationale or disincentives, and a cost-benefit analysis for each:

(1) a statutory directive to the Department of Mental Health to prioritize the restoration of competency where possible for all forensic patients committed to the care of the Commissioner; and

(2) enabling applications for involuntary treatment and applications for involuntary medication to be filed simultaneously or at any point that a psychiatrist believes joint filing is necessary for the restoration of the individual's competency.

(b) The Chief Administrative Judge of the Vermont Superior Courts, in consultation with the Department of Mental Health, shall conduct an analysis that examines mechanisms to increase efficiency and to expeditiously resolve cases filed pursuant to18 V.S.A. chapter 181, including issues relating to changes of venue, scheduling of hearings, judicial caseloads, the causes for any delays in the process of scheduling and resolving cases, and any proposals to improve the efficient resolution of cases without reducing the due process afforded to patients.

(c) On or before January 15, 2018, Vermont Legal Aid and Disability Rights Vermont shall jointly submit an addendum addressing those portions of the Secretary's proposed action plan submitted pursuant to Sec. ~~2~~ 3 of this act that relate to subsection (a) and (b) of this section.

(d)(1) On or before November 15, 2017, the Department shall issue a request for information for a longitudinal study comparing the outcomes of patients who received court-ordered medications while hospitalized with those of patients who did not receive court-order medication while hospitalized, including both patients who voluntarily received medication and those who received no medication, for a period from 1998 to the present. The request for information shall specify that the study examine the following measures:

(A) the length of an individual's involuntary hospitalization

(B) the time spent by an individual in inpatient and outpatient settings;

(C) the number of an individual's hospital admissions, including both voluntary and involuntary admissions;

(D) the number of and length of time an individual's residential placements;

(E) an individual's successes in different types of residential settings;

(F) any employment or other vocational and educational activities after hospital discharge;

(G) any criminal charges after hospital discharge; and

(H) other parameters determined in consultation with representatives of inpatient and community treatment providers and advocates for the rights of psychiatric patients.

(2) Request for information proposals shall include estimated costs, time frames for conducting the work, and any other necessary information.

* * * Payment Structures * * *

Sec. 6. INTEGRATION OF PAYMENTS; ACCOUNTABLE CARE ORGANIZATIONS

(a) Pursuant to 18 V.S.A. § 9382, the Green Mountain Care Board shall review an accountable care organization's (ACO) model of care and integration with community providers, including designated and specialized

service agencies, regarding how the model of care promotes seamless coordination across the care continuum, business or operational relationships between the entities, and any proposed investments or expansions to community-based providers. The purpose of this review is to ensure progress toward and accountability to the population health measures related to mental health and substance use disorder contained in the All Payer ACO Model Agreement.

(b) In the Board's annual report due on January 15, 2018, the Green Mountain Care Board shall include a summary of information relating to integration with community providers, as described in subsection (a) of this section, received in the first ACO budget review under 18 V.S.A. § 9382.

(c) On or before December 31, 2020, the Agency of Human Services, in collaboration with the Green Mountain Care Board, shall provide a copy of the report required by Section 11 of the All-Payer Model Accountable Care Organization Model Agreement, which outlines a plan for including the financing and delivery of community-based providers in delivery system reform, to the Senate Committee on Health and Welfare and the House Committee on Health Care.

Sec. 7. PAYMENTS TO THE DESIGNATED AND SPECIALIZED SERVICE AGENCIES

The Secretary of Human Services, in collaboration with the Commissioners of Mental Health and of Disabilities, Aging, and Independent Living, shall develop a plan to integrate multiple sources of payments to the designated and specialized service agencies. In a manner consistent with Sec. 10 of this act, the plan shall implement a Global Funding model as a successor to the analysis and work conducted under the Medicaid Pathways and other work undertaken regarding mental health in health care reform. It shall increase efficiency and reduce the administrative burden. On or before January 1, 2018, the Secretary shall submit the plan and any related legislative proposals to the Senate Committee on Health and Welfare and the House Committee on Health Care.

Sec. 8. ALIGNMENT OF FUNDING WITHIN THE AGENCY OF HUMAN SERVICES

For the purpose of creating a more transparent system of public funding for mental health services, the Agency of Human Services shall continue with budget development processes enacted in legislation during the first year of the 2015–2016 biennium that unify payment for services, policies, and utilization review of services within an appropriate department consistent with Sec. 6 of this act.

* * * Workforce Development * * *

Sec. 9. MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE USE DISORDER WORKFORCE STUDY

COMMITTEE

(a) Creation. There is created the Mental Health, Developmental Disabilities, and Substance Use Disorder Workforce Study Committee to examine best practices for training, recruiting, and retaining health care providers and other service providers in Vermont, particularly with regard to the fields of mental health, developmental disabilities, and substance use disorders. It is the goal of the General Assembly to enhance program capacity in the State to address ongoing workforce shortages.

(b)(1) Membership. The Committee shall be composed of the following members:

(A) the Secretary of Human Services or designee, who shall serve as the Chair;

(B) the Commissioner of Labor or designee;

(C) a representative of the Vermont State Colleges; and

(D) a representative of the Vermont Health Care Innovation Project's (VHCIP) work group.

(2) The Committee may include the following members:

(A) a representative of the designated and specialized service agencies appointed by Vermont Care Partners;

(B) the Director of Substance Abuse Prevention;

(C) a representative of the Area Health Education Centers; and

(D) any other appropriate individuals by invitation of the Chair.

(c) Powers and duties. The Committee shall consider and weigh the effectiveness of loan repayment, tax abatement, long-term employment agreements, funded training models, internships, rotations, and any other evidence-based training, recruitment, and retention tools available for the purpose of attracting and retaining qualified health care providers in the State, particularly with regard to the fields of mental health and substance use disorders.

(d) Assistance. The Committee shall have the administrative, technical, and legal assistance of the Agency of Human Services.

(e) Report. On or before September 1, 2017, the Committee shall submit a report to the Senate Committee on Health and Welfare and the House Committee on Health Care regarding the results of its examination, including any legislative proposals for both long-term and immediate steps the State may take to attract and retain more health care providers in Vermont.

(f) Meetings.

(1) The Secretary of Human Services shall call the first meeting of the Committee to occur on or before July 1, 2017.

(2) A majority of the membership shall constitute a quorum.

(3) The Committee shall cease to exist on September 30, 2017.

Sec. 10. OFFICE OF PROFESSIONAL REGULATION; INTERSTATE COMPACTS

The Director of Professional Regulation shall engage other states in a discussion of the creation of national standards for coordinating the regulation and licensing of mental health professionals, as defined in 18 V.S.A. § 7101, for the purposes of licensure reciprocity and greater interstate mobility of that workforce. On or before September 1, 2017, the Director shall report to the Senate Committee on Health and Welfare and the House Committee on Health Care regarding the results of his or her efforts and recommendations for legislative action.

* * * Designated and Specialized Service Agencies * * *

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

§ 8914. RATES OF PAYMENTS TO DESIGNATED AND SPECIALIZED SERVICE AGENCIES

(a) The Secretary of Human Services shall have sole responsibility for establishing rates of payments for designated and specialized service agencies that are reasonable and adequate to meet the costs of achieving 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 cost 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.

Sec. 12. HEALTH INSURANCE; DESIGNATED AND SPECIALIZED SERVICE AGENCY EMPLOYEES

On or before September 1, 2017, the Commissioner of Human Resources shall consult with Blue Cross and Blue Shield of Vermont and Vermont Care Partners regarding the operational feasibility of including the designated and specialized service agencies in the State employees' health benefit plan and submit any findings and relevant recommendations for legislative action to the Senate Committees on Health and Welfare, on Government Operations, and on Finance and the House Committees on Health Care and on Government Operations.

Sec. 13. PAY SCALE; DESIGNATED AND SPECIALIZED SERVICE AGENCY EMPLOYEES

It is the intent of the General Assembly that funds be appropriated to designated and specialized service agencies, for the following purposes:

(1) in fiscal year 2018, to fund increases in the hourly wages of workers to $14.00 and to increase the salaries for crisis response team personnel to be at least 85 percent of those salaries earned by regionally equivalent State, health care, or school-based positions of equal skills, credentials, and lengths of employment

(2) in fiscal year 2019, to fund increases in the hourly wages of workers to $15.00 and to increase the salaries for clinical employees and other personnel in a manner that advances the goal of achieving competitive compensation to regionally equivalent State, health care, or school-based positions of equal skills, credentials, and lengths of employment; and

(3) in fiscal year 2020, after the completion of a market rate analysis by the designated and specialized service agencies, to further increase the salaries for clinical employees and personnel in a manner that advances the goal of achieving competitive compensation to regionally equivalent State, health care, or school-based positions of equal skills, credentials, and lengths of employment.

* * * Effective Date * * *

Sec. 14. EFFECTIVE DATE

This act shall take effect on passage.

(Committee vote: _____)

_____

Representative _____

FOR THE COMMITTEE