VERMONT

**State of Vermont**
Department of Mental Health
280 State Drive, NOB 2 North
Waterbury, VT 05671-2010
http://mentalhealth.vermont.gov/

*Agency of Human Services*

[phone] 802-241-0090
[fax] 802-241-0100
[tty] 800-253-0191

# MEMORANDUM

TO: Representative William J. Lippert Jr., Chair, House Committee on Health Care

CC: Senator Virginia Lyons, Chair, Senate Committee on Health and Welfare

FROM: Sarah Squirrell, Commissioner, Department of Mental Health
Mourning Fox, Deputy Commissioner, Department of Mental Health

DATE: January 31, 3019

SUBJECT: Department of Mental Health Overview, Questions and Answers

---

Please find below and attached, information from the Department of Mental Health submitted in response to inquiries received during and after testimony to the House Committee on Health Care on January 24, 2019.

# MENTAL HEALTH SYSTEM OF CARE OVERVIEW

## QUESTIONS AND ANSWERS

Source: *HHC*

**Q1**: Please clarify the relationship between an IEP and the ability to receive school-based services.

**A1:** While Success Beyond Six is not a statutorily defined program, requirements at Title 33, Chapter 43 regarding Children and Adolescents with Severe Emotional Disturbance apply. Eligible children (VT=312% FPL) with assessed need are entitled to medically necessary community MH services under the Medicaid State Plan and federal Early Periodic Screening Diagnosis and Treatment (EPSDT) requirements. The Medicaid State Plan allows these services to be provided by DAs in any setting, including schools. There are three service components under Success Beyond Six: Behavior Interventionist Programs (BIs), School-Based Clinicians, and CERT (Concurrent to Education Rehabilitation and Treatment).

The school identifies the initial need for student-specific mental health services as well as school-wide mental health consultation and support, and may contract with the DA for the school based mental health (SBMH) services. Schools chose whether to contract with DAs to provide services. This is influenced by the existing resources of the individual schools and what they need to supplement their resources to best meet the needs of their school and students. Not all schools choose to contract with DAs:

| FY18 (report run 2/2018) | |
|---|---|
| Total schools with DA SBMH contracts | 228 |
| Total school in VT (public and independent) | 297 |
| % of schools collaborating with DAs for SBMH | 77% |

The contracted DA conducts a clinical assessment by a Master's level (or higher) clinician of the specific student need, including a functional behavioral assessment when BI services are requested, to determine medical necessity for school-based mental health services. An individualized plan of care is developed based on this assessment which guides the treatment and interventions, aligned with Medicaid regulations.

School mental health services and supports do not require an IEP, in fact for the school-based clinicians, the case rate was created to allow more flexibility for them to provide supports, services, consultation to a broader school population in addition to

direct clinical intervention with students with identified mental health needs. The school mental health supports can actually help children have a reduced need for special education if their emotional needs are supported and thus reduce the potential impact their academics. For the BI services, the majority of those students received special education services (IEP), but not all. The FY18 data is below:

**BI Students' Education Status (school year 2017-2018)**

| | |
|---|---|
| Total number of students accessing BI services | 327 |
| Individualized Education Program (IEP) | 285 |
| 504 Plans | 32 |
| Educational Support Team | 6 |
| No plan | 4 |

Source: HHC, SHW

**Q2**: At several points the committees requested a visual of where mental health resources are located in Vermont. The requests were focused on residential and inpatient levels of care and were requested for both adults and children.

**A2:** The Department of Mental Health has created and attached to this memorandum a resource map of publicly funded mental health facilities in Vermont. The map shows county sub-divisions and lists both DA and non-DA resources for adults and children. Additional information about associated costs is also attached.

Source: HHC

**Q3:** The Committee on House Health Care expressed interest in understanding how and if the Department of Mental Health is collaborating with institutions of higher education in the State.

**A3:** The Department of Mental Health is aware of a variety of collaborations by DAs and is working with the Vermont Care Partners to share back additional information to the committee.

DMH provides funding for the child psychiatry fellowship training program administered by the Vermont Center for Children, Youth, and Families (VCCYF) of the University of Vermont's College of Medicine and The University of Vermont Medical Center to promote training of child psychiatrists in the family based, health promotion approach. Child psychiatrists are one of the least available specialists in Vermont and in the country as a whole. They have repeatedly been identified as one of the greatest unmet needs in child mental health care. Fellows from child psychiatry frequently choose to stay in the same area after graduation. DMH also collaborates with the UVM VCCYF (under Dr. James Hudziak) and the UVM Vermont Child Health Improvement Program to bring practice improvement initiatives on mental health topics to the public mental health and primary care providers.

Additionally, DMH is collaborating with DCF-Family Services and the UVM Department of Social Work's Child Welfare Training Partnership to support courses for Bachelor's- and Master's- level students and post-graduate certificates on topics such as trauma and adoption competence.

Source: HHC

**Q4**: The Committee requested that peer-run services be included more prominently in the Adult System of Care graphic shared by the Department.

**A4**: An updated version of the Adult System of Care graphic is attached that more clearly includes peer-run organizations.

Source: HHC

**Q5**: The committee asked if there are notable difference in the quality of DA services provided across the state.

**A5**: Quality review of Designated (DA) and Specialized Services Agencies (SSA) are described in the recently submitted Act 82, Section 3(c) report, An Evaluation for the Overarching Structure for the Delivery of Mental Health Services. The information below is excerpted from the quality section of that report and includes a report card of DA and SSA designation status.

### 6.4 Quality review of Designated and Specialized services Agencies

Compliance and quality oversight of the DA/SSAs related to designation runs on a four-year cycle and consists of three separate oversight processes

1. Minimum Standards Chart Review
2. Agency Review
3. Designation

Each quality oversight process assesses the agencies on a specific set of standards informed by state and federal requirements.

1. **Minimum Standards Chart Reviews** are conducted at each DA/SSA during the four-year cycle. Criteria used to create the review standards are based on state and federal regulations and laws. Chart reviews examine 33 different criteria in seven different sections for adults and 61 criteria over 11 sections for children/youth to assess the agency's ability to meet the standard of care and provide quality services. Agencies are given an overall score for each standard, section, and overall quality. If a section falls below a determined threshold, the agency is required to complete a corrective action plan to come into compliance. The corrective action plan must be submitted to the Department of Mental Health (DMH) for approval and completed within 180 days of the findings.
2. Additionally, DMH completes **Agency Reviews** prior to designation, which affords the department a more in-depth programmatic review and offers the

agency an opportunity to correct areas that the department anticipates being potential issues prior to designation. DMH analyzes licensure, staffing ratios, use of evidence-based practices, SWOT analysis, utilization review, internal assessment of quality, policies, trainings, and use of standardized tools. DMH also surveys agency staff, community stakeholders, and the local program standing committee to assess local opinions about the quality of care that the agency is providing.

3. Lastly, **Designation** completes the quality and compliance process in the four-year cycle. For each population served by the Department of Mental Health, the Commissioner designates one agency in each geographic area of the state to assure that people in local communities receive services and supports, consistent with available funding, the state System of Care Plans, the local System of Care Plans, outcome requirements, regulations promulgated by DMH, the goals of Vermont for its citizens, the goals of the citizens themselves, and other policies, plans, regulations, and laws.

   The designation process is the most intensive of the three processes and involves a review of more than 100 standards of varying weights across 16 distinct sections. A site review is conducted at each agency undergoing re-designation so that DMH staff can interview the agency board, senior leadership, staff, the local program standing committee, stakeholders, who include clients receiving services. The department also solicits public comment and incorporates the feedback into the findings. If areas are found to be out of compliance, the agency is required to complete a corrective action plan that the department must approve. Unless extenuating circumstances exist, agencies must come into compliance within 180 days.

## Designated Agency and Specialized Services Agency Designation Status

| **Agency redesignation (2016 - 2020)** | | | |
|---|---|---|---|
| DA/SSA | Designation Time Frame | Corrective Action Plan | Status of **Current** Designation |
| **Lamoille County Mental Health Services** | 5/25/18-5/25/22 | Yes | Re-designated with Minor Deficiencies |
| **Northeast Kingdom Human Services** | 7/25/18-7/25/22 | Yes | Re-designated with Minor Deficiencies |
| **Healthcare and Rehabilitation Services** | 10/19/18-10/19/22 | Yes | Re-designated with Minor Deficiencies |
| **Currently in the process of redesignation**… | | | |

| DA/SSA | Designation Time Frame | Corrective Action Plan **Previous** Designation | Status of **Previous** Designation |
|---|---|---|---|
| **Washington County Mental Health Services** | Pending, expires 1/23/19 | Yes | Re-designated with Minor Deficiencies |
| **Northwestern Counseling and Support Services** | Pending, expires 4/29/19 | Yes | Re-designation with Minor deficiencies |
| **Rutland Mental Health Services** | Pending, expires 7/28/19 | Yes<br>RMHS had 180 days to work with DMH to correct deficiencies and avoid de-designation, which they completed | Provisional Redesignation with Intent to De-designate, ***Resolved*** |
| **Designation findings from previous cycle (2012-2016)** | | | |
| **Clara Martin Center** | 9/25/15-9/25/19 | Yes | Re-designated with minor deficiencies |
| **Howard Center** | 1/26/16-1/26/20 | No | Re-designated —No Further Action Required |
| **Northeastern Family Institute** (children only) | 3/27/16-3/27/20 | Yes | Re-designated with Minor Deficiencies |
| **United Counseling Service** | 4/29/16-4/29/20 | Yes | Re-designated with Minor Deficiencies |
| **Counseling Services of Addison County** | 7/29/16-7/29/20 | Yes | Re-designated with Minor Deficiencies |
| **Pathways Vermont** (adult only) | 10/3/16-10/3/20 | Yes | Designate (initial designation) |

Source: HHC

**Q6**: The Committee asked questions about services covered by Medicaid vs. coverage of other insurers.

**A6**: General information about coverage of mental health services by Medicaid, Medicare and Commercial insurers is included in the recently submitted Act 82, Section 3(c) report, An Evaluation for the Overarching Structure for the Delivery of Mental Health Services, and is excerpted below. More detail regarding specific service definitions and provider types is provided elsewhere in the report.

## Who pays for Mental Health Services

Vermonters access insurance in many different ways- from their employer, from the federal government, from state government, or by purchasing it themselves on the insurance marketplace, Vermont Health Connect. Parity laws do not apply to all plans in the same way, and not all types of health insurance are covered by the Federal Parity Law or a state parity law.

The Mental Health Parity and Addiction Equity Act was passed in 2008 and requires health insurance plans to cover mental health benefits and physical health benefits equally. The Federal Parity Law says that health insurance plans cannot have higher co-payments and other out-of-pocket expenses for mental health benefits than they do for other medical benefits; health insurance plans cannot put higher limitations on the number of visits or days of coverage for mental health care than they do for other medical care; and, health insurance plans cannot use more restrictive managed care practices for mental health benefits than they use for other medical benefits.

The Federal Parity Law does not require that all health insurance plans cover mental health care, but if they do, the coverage must be comparable to what's in place for other medical care.

**Medicare**

Medicare covers Inpatient Hospital (Part A), Outpatient (Part B), and Prescription Drugs (Part D) for mental health.

> *Inpatient Hospital* (Part A) covers things like: room, meals, nursing care, therapy or other treatment, lab tests, medications, and other related services and supplies. If the services are provided in a psychiatric hospital, Medicare only pays for up to 190 days of inpatient psychiatric hospital services during a person's lifetime.
>
> *Outpatient* (Part B) covers things like: visits with a psychiatrist or other doctor, visits with a clinical psychologist or clinical social worker, and lab tests ordered by a doctor. Outpatient coverage may also pay for partial hospitalization services if someone needs intensive coordinated outpatient care.
>
> *Prescription Drugs* (Part D) helps cover drugs that may be needed to treat a mental health condition.

Medicare will cover mental health services if they are provided by the following types of qualified providers: psychiatrist or other doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, or physician assistant.

**Medicaid**

Medicaid covers inpatient hospital, outpatient and prescription drugs for mental health. A listing of benefits and qualified providers are described in the prior section and

include Inpatient Psychiatric Hospital (no limit), Outpatient, Emergency/Crisis Services, Over-the-Counter and Prescription Drugs; and Transportation.

Through the Global Commitment to Health Waiver and its Medicaid State Plan, Vermont Medicaid covers additional benefits for some Vermonters with additional mental health needs. These services are described at 2.3 D) through R) of the report, and include services such as service planning and coordination, community supports, supported employment, day services, special evaluations, family education/consultation, respite, and a variety of levels and types of residential settings. Medicaid also enrolls mental health professionals who are not covered by Medicare.

**Commercial**

In the state of Vermont, every plan must provide minimum essential coverage, which is coverage of the following 10 basic health benefits, including mental health:

- Children's health services
- Emergency care
- Hospitalization
- Lab services
- Maternity and newborn care
- Mental health and substance abuse services
- Outpatient services
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices

Although the specifications of covered services under the mental health benefit will vary among different commercial plans, as described in the introduction of this section of the report, the coverage must be comparable to what's in place for other medical care.

### Summary

- Mental Health services are provided at all levels of care and in just about any location.
- Mental health services are paid for by all major categories of insurers; Medicaid, Medicare and Commercial, however, benefits, provider qualifications and coverage of mental health services vary between payers.
- Medicaid coverage for mental health services and inclusion of qualified provider types is more extensive than Medicare or Commercial insurance. In particular,

Medicaid pays for individuals to receive services in an inpatient hospital without life-time limits such as those imposed by Medicare and pays for residential levels of care in the community that are generally not covered by other insurers.

Source: HHC

**Q7:** The Committee asked for more information about the URS data source used to create the national and state comparisons of use over time of the State Hospital, Inpatient and Community Services.

**A7**: The Department of Mental Health has compiled and attached to this memorandum a detailed chart with the data from the Uniform Reporting System (URS).

- For both the State-Hospital inpatient and Community Setting data, the Department of Mental Health Research and Statistics unit collects this from the Service files from the Monthly Service Report (MSR) data provided by the Designated Agencies to the State of Vermont, Department of Mental Health.
- The data is collected for the Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System. SAMHSA provides detailed instructions on what should be included in each calculation, and therefore the state and national comparison is as valid as can be reasonably expected, assuming other states follow the specifications closely as well.
- The two graphs shown in the DMH overview illustrate the number of clients that received public funded mental health services in community mental health settings and in state psychiatric hospitals.
- The data does not include clients with a primary program assignment of Developmental Services or Alcohol Drug Abuse Programs, nor does it include Community and Education Program data.
- For state hospital data
    1. States that have country psychiatric hospitals that serve as surrogate state hospitals report persons served in such settings as receiving services in state hospitals
    2. If forensic hospitals are part of the state mental health agency system they are included
    3. Persons who receive inpatient psychiatric care through a private provider or medical provider licensed and/or contracted through the SMHA should be counted in the “Other Psychiatric Inpatient” row (not in state hospitals.)

Source: HHC

**Q8:** The Committee asked questions about staffing requirements for inpatient mental health providers and the Department offered to provide a view of the staffing matrix for the Vermont Psychiatric Care Hospital.

**A8:** While there are no statutory requirements regarding staffing levels, there are guidelines and best practices. See attached, information about the staffing matrix of the Vermont Psychiatric Care Hospital.

Source: HHC

**Q9:** The Committee was interested in understanding more about use of overtime at the Vermont Psychiatric Care Hospital.

**A9:** Please see attached, information about overtime use at the Vermont Psychiatric Care Hospital.

Source: HHC

**Q10:** The Committee questioned the plateau of community services utilization as presented in the national vs. state comparison slides.

**A10:** Although Vermont is exceeding per capita utilization nearly two times as much as US standards, this rate is not increasing. The Department of Mental Health does not have a definitive response as to why. The small number changes are not statistically significant but there is room to suggest more capacity is needed.

Source:

**Q11:** The Committee requested an overview of of peer/consumer involvement in payment reform, value-based payments and how they are engaged in ongoing feedback.

**A11:** The Department's payment reform process over the past year included a Steering Committee with consumer/peer members as well as ongoing feedback loops with the state standing committees, local program standing committees, and Act 264 Advisory Board, as well as individual presentations to a variety of other advocacy and state advisory groups. The Department is reviewing ongoing opportunities for consumer/ peer engagement now that payment reform has been implemented and plans that any ongoing advisory groups, such as the metrics and scoring workgroup that started in November, must have explicit peer/consumer feedback loops.

Source: HHC, Rep. Donahue email

**Q12:** Are there reports available from the children's psychotropic trend monitoring group?

**A12:** The Department is pleased to share any information available regarding the work of the psychotropic trend monitoring group. While there are no reports, there are meeting minutes that may be shared with anyone who wishes to view them.

Source: HHC, Rep. Donahue email

**Q13:** Adult inpatient utilization trends: What is data on voluntary vs involuntary? (distinct subcomponent of DMH responsibility).

**A13:** The Department will be providing this information to the Legislative on or before Thursday, January 31, 2019 as a part of the Act 200, Section 7 report.

Source: HHC, Rep. Donahue email

**Q14:** Community mental health capacity: Peer-run services "to build on and improve" are not referenced (language on expanding services limits to programs delivered by DAs) – why?

**A14:** Slide 31 of 46 on Community Mental Health Capacity refers to needs that communities have and provides two examples of needs relating to designated agencies. These were provided as examples and not meant to be an exhaustive list of unmet needs. Peer run programs are used as examples in the second half of the same slide.

Source: HHC, Rep. Donahue email

**Q15:** Are community services also paid for by/person eligible when, private insurance? Crisis beds, etc … e.g., I understand START is only accessible to Medicaid clients (unless paid out-of-pocket. We have a parity law – is it not being enforced?

**A15:** Every payer of health care services may include cost sharing requirements for any services. See also response to question 6 regarding federal parity requirements regarding cost sharing and coverage of mental health services by other payers. Overall, AHS pays for publicly funded services but has limited visibility into what is paid for by other insurers. AHS does not enforce payment from other insurers except that Medicaid is the payer of last resort and requires providers to follow claims payment rules regarding a billing of any other source of coverage prior to billing Medicaid. DFR may be another source of information regarding oversight and enforcement.

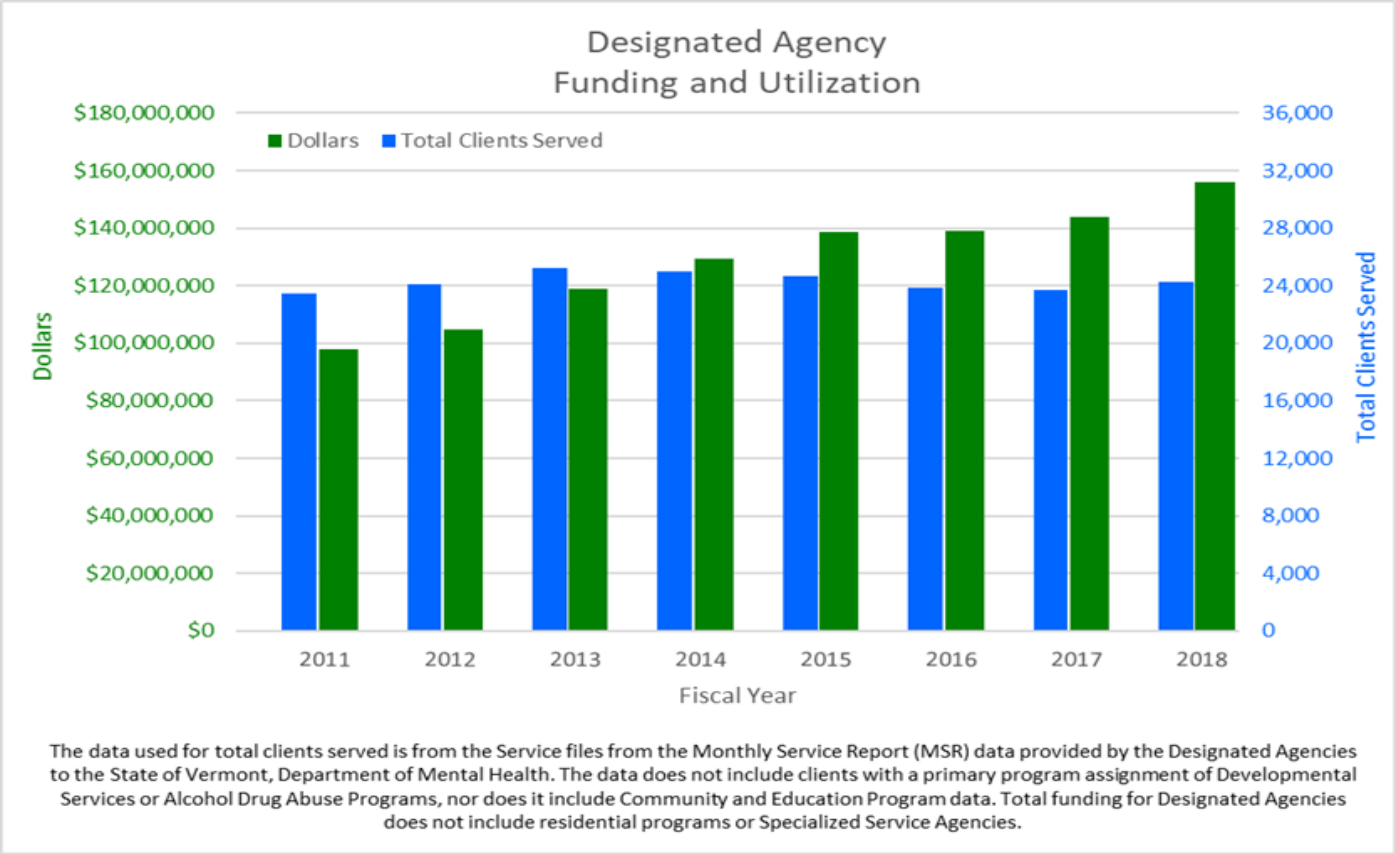
Source: HHC, Rep. Donahue email

**Q16:** What is the spending trend for community services? (vs utilization)(as shown on slide for Success after Six)

**A16:** The below chart describes expentiures for community based services since 2011 against the numbers of consumers served. The data used for total clients served is from the service files in the Monthly Service Report (MSR) data provided by the Designated Agencies to the State of Vermont, Department of Mental Health.

The data does not include clients with a primary program assignment of Developmental Services or Alcohol Drug Abuse Programs, nor does it include Community and Education

Program data. Total funding for Designated Agencies does not include residential programs or Specialized Service Agencies.




Source:

HHC, Rep. Donahue email

**Q17:** Status of report on sheriff transport? (Doesn't seem to be in yet.)

**A17:** This question has been referred to the Agency of Human Services central office for further follow up.