VERMONT

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Agency of Human Services

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MEMORANDUM

TO: Representative William J. Lippert Jr., Chair

FROM: Sarah Squirrell, Commissioner, Department of Mental Health

DATE: January 16, 2020

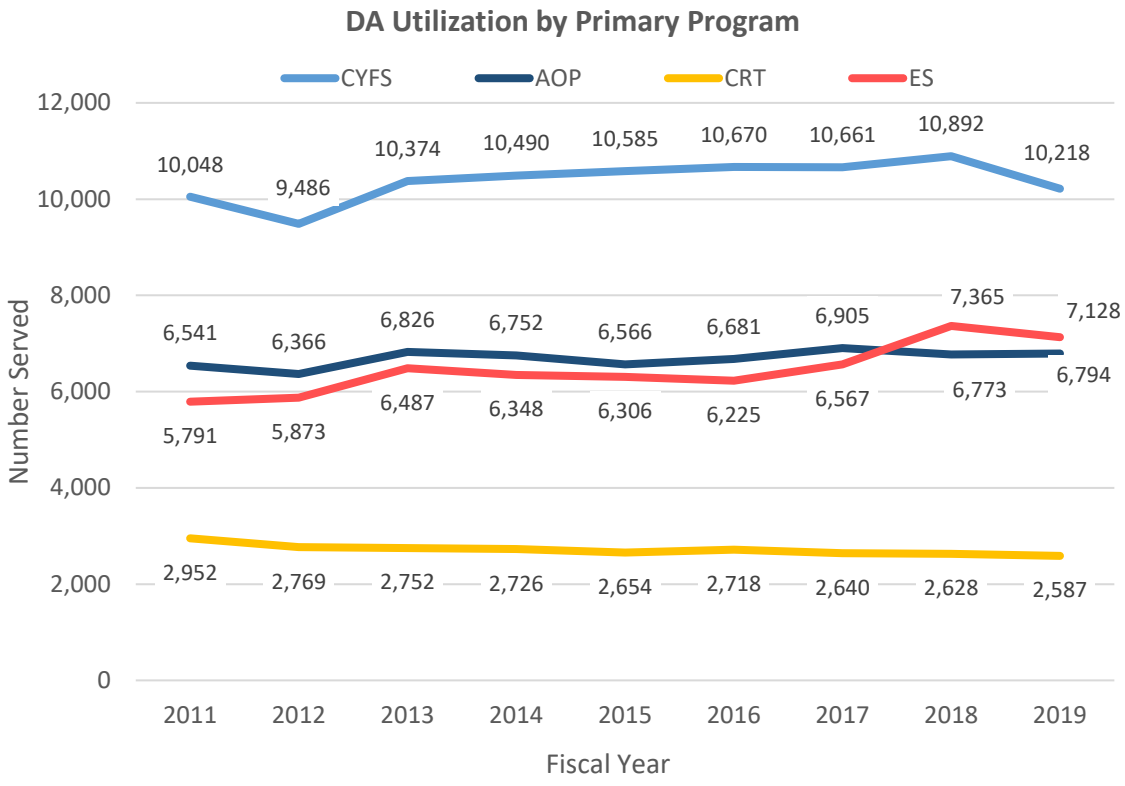
SUBJECT: Follow up to Questions Received During Testimony on 1/8/2020 and 1/10/2020

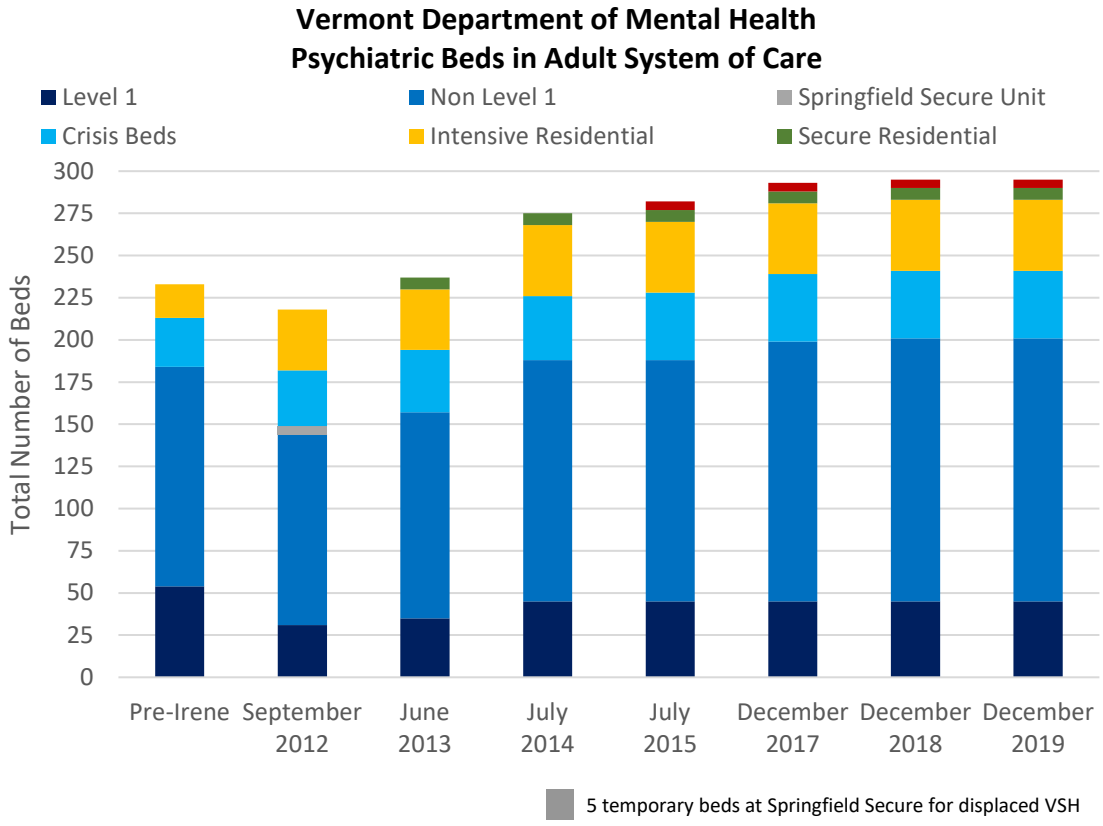
Please see below for responses to questions received during testimony on January 8th and January 10th by the Vermont Department of Mental Health.

Questions from 1/8/2020-

Q1: Please provide System of Care census data to committee.

The table following tables show numbers served in Community-based and Hospital levels of Care since Fiscal Year 2011.





Q2: Please share a complete census/occupancy numbers for Brattleboro Retreat.

The table below is a point-in-time census of The Retreat, as of Thursday afternoon, January 9, 2020

Inpatient Unit	Beds Occupied/Capacity	Closed Beds	Females	Males	Instate	Out-of-State	Vol	Invol
O1 (children's unit)	9/12	0 closed	5	4	6	3	Unknown	
T3 (adolescent)	17/18	0 closed	9	8	10	7	Unknown	
O2 (LGBT)	0/15	15 closed	N/A	N/A	N/A	N/A	N/A	
O3 (emerging adult)	12/14	0 closed	8	4	7	5	All	
T1 (Co-occurring)	16/22	5 closed	8	8	12	4	All	
T2 (Acute adult)	23/24	0	8	15	17	6	17	6
T4 (Level 1)	13/14	0 closed	7	6	9	4	2	11
Totals:	90/119 (75.6% occupancy rate)	0 closed	45	45	61 (68%)	29 (32%)	47	17

Q3: Please share state map of beds showing how bed capacity lines up with adult inpatient needs.

Please see state map of residential and deignated hospital beds by County, on the following page.

DMH Residential and Designated Hospital Beds by County FY19

BR	Brattleboro Retreat
CMC	Clara Martin Center
CSAC	Counseling Service of Addison County
CSC	Collaborative Solutions, Corp
CVMC	Central Vermont Medical Center
FAHC	Fletcher Allen Health Center
HC	Howard Center
HCRS	Health Care Rehabilitation Services of Southern Vermont
LCMH	Lamoille County Mental Health
NKHS	Northeast Kingdom Human Services Inc.
PW	Pathways
RMHS	Rutland Mental Health Services
RRMC	Rutland Regional Medical Center
UCS	United Counseling Services
VA	Veterans Administration
WC	Windham Center
WCMH	Washington County Mental Health

*NFI HDP-S Capacity 6, Currently only 4 open beds

**Residential programs that are primarily utilized by DCF, but accessible to DMH in rare circumstances

VERMONT

Questions from 1/10/2020-

Q4: Can you give us a sense of the children's #s of in-state vs. out-of-state?

In addition to information about children served at the Brattleboro Retreat provided at Q2, please see attached for "State Residential Data, Qtr. 4 FY 2019" report from the Vermont Agency of Human Services Residential Turn the Curve Advisory Committee, which describes the statewide total bed days and total number of children placed in residential by State fiscal year, broken down by funding department.

Q5: Can you give us the Brattleboro Retreat rate increases over the past several years?

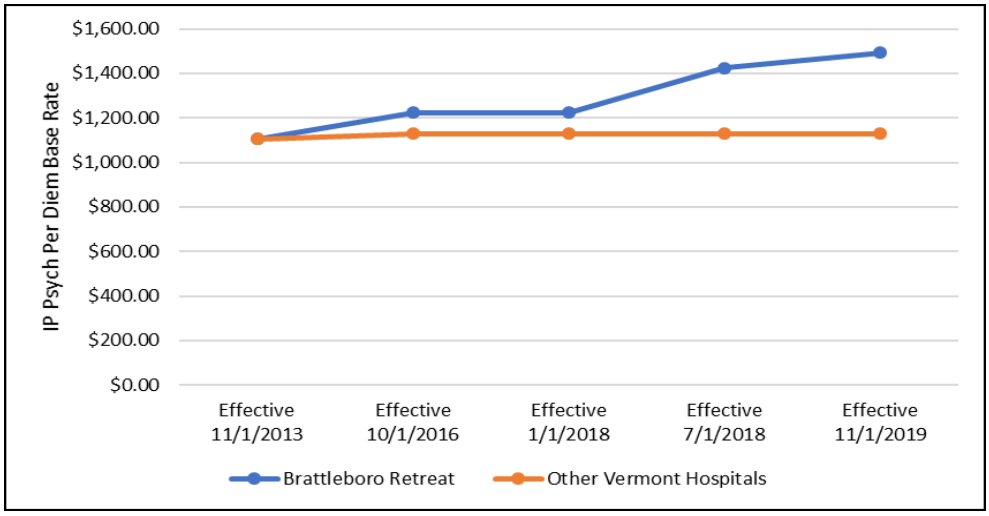
DVHA and DMH reimburse for inpatient psychiatric hospitalizations in two ways.

- Level 1 claims are paid at a per diem rate and then cost settled. Act 79 requires "reasonable actual" reimbursement of costs for the Level I hospitals, which happens on an annual basis.The cost settlement from the previous year is then taken into account in the new rates established in the following year.

- For all other types of inpatient psychiatric claims, Vermont uses the Inpatient Prospective Payments System (IPPS) combined with a factor based on number of days. Under the IPPS, each hospital stay is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. DRG assignment (grouping) happens at the claim level and utilizes information billed such as diagnosis codes, procedures codes, age of patient, etc.

Inpatient Psych Per Diem
Formula: Hospital Base Rate x DRG Weight x Length of Stay Factor

	Brattleboro Retreat		Other Vermont Hospitals		Dartmouth Hitchcock	
Inpatient Psychiatric Per Diem Base Rate	$	% Change	$	% Change	$	% Change
Effective 11/1/2013	$1,104.60		$1,104.60		N/A	
Effective 10/1/2016	$1,224.10	10.82%	$1,128.05	2.12%	N/A	
Effective 1/1/2018	$1,224.10		$1,128.05		$1,128.05	
Effective 7/1/2018	$1,425.00	16.41%	$1,128.05		$1,128.05	
Effective 11/1/2019	$1,493.00	4.77%	$1,128.05		$1,128.05	



Brattleboro Retreat Base Rate History:

		For Dates of Service Beginning	For Dates of Service Beginning	For Dates of Service Beginning	For Dates of Service Beginning	For Dates of Service Beginning	For Dates of Service Beginning	For Dates of Service Beginning
Provider ID	Description	11/1/2013	1/1/2014	1/1/2016	10/1/2016	7/1/2018	1/1/2019	11/1/2019
474001	Children's Inpatient Psych	$ 1,104.60	→		$ 1,224.00	$ 1,425.00	→	$ 1,493.00
1006874	BRATTLEBORO RETREAT ADULT	$ 1,104.60	→		$ 1,128.05	$ 1,425.00	→	$ 1,493.00
1020639	BRATTLEBORO RETREAT Level 1		$ 1,375.00	$ 1,425.00			$ 1,572.00	→
1007212	BRATTLEBORO RETREAT CRT	$ 1,104.60	→		$ 1,128.05	$ 1,425.00	→	$ 1,493.00

SFY Date of Service Impact for Each Rate Change

Provider ID	Description	SFY 2016	SFY 2017	SFY 2018	SFY 2019
474001	Children's Inpatient Psych	n/a	$ 591,561	$ 939,013	$ 1,471,812
1006874	BRATTLEBORO RETREAT ADULT	n/a	$ 127,184	$ 189,809	$ 3,165,103
1020639	BRATTLEBORO RETREAT Level 1	$ 102,400	$ 139,000	$ 189,150	$ 193,800
1007212	BRATTLEBORO RETREAT CRT	n/a	$ 55,097	$ 67,914	$ 820,999
		$ 102,400	$ 912,842	$ 1,385,887	$ 5,651,713

Q6: When you say child/youth residential, those are the beds you showed us – NFI, Retreat and Jarrett House? Please provide list of those beds where they are to this committee.

Please see the map at Q3 of this document as well as information provided in the attached State Residential Data report.

Q8: Please update the BAA talking points to include bottom line summaries.

Please see attached.

State Residential Data

Qtr. 4 FY 2019

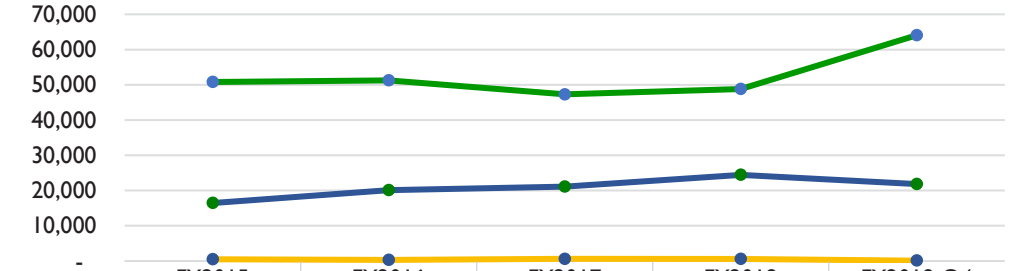
Vermont Agency of Human Services Residential
Turn the Curve Advisory Committee

280 State St., NOB 2 North, Waterbury, VT 05671-2090, (Questions? Call 802-241-0155)

STATE DATA

The following charts represent the statewide total bed days and total number of children placed in residential by State fiscal year, broken down by funding department. If a child changed custody status within a fiscal year (i.e. child in DCF custody returned to parent's custody but remained in residential program), the child is counted under both Departments in the Total Child Count chart; the actual bed days are attributed to the respective department in Total Residential Bed Days.

Total Residential Bed Days by Department per Fiscal Year Through FY19Q4



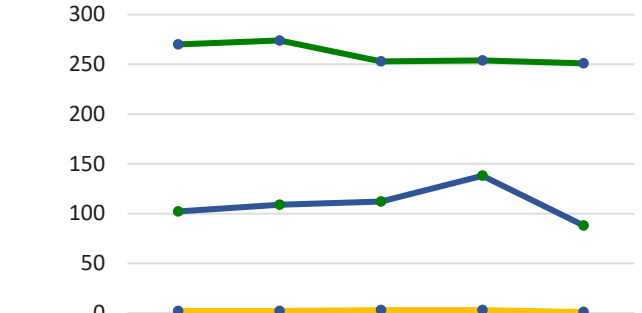
	FY2015	FY2016	FY2017	FY2018	FY2019 Q4
DCF	50,835	51,220	47,305	48,794	64,076
DMH	16,449	20,145	21,120	24,437	21,864
DAIL	511	289	623	598	99

unduplicated count

Total Bed Days

Total Bed Days is the total number of days a child/ youth stays overnight in a residential program. For the Total Bed Days chart, children who were placed in more than one program during the fiscal year are represented more than once so that all bed days are calculated.

Total Child Count Residential by Department per Fiscal Year Through FY19Q4



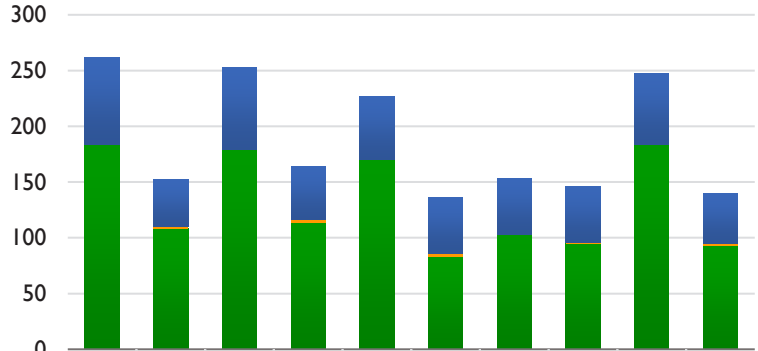
	FY2015	FY2016	FY2017	FY2018	FY2019 Q4
DCF	270	274	253	254	251
DAIL	2	2	3	3	1
DMH	102	109	112	138	88

unduplicated count

Total Child

For the Total Child Count in Residential by State fiscal year, the number of children/youth is undu- plicated within the fiscal year, meaning if a child/ youth was placed in more than one residential program during the fiscal year, the child/youth is only counted once.

Instate and Out-of-State Residential Count Through FY19Q4



	Instate	Out of state	Instate	Out of state	Instate	Out of state	Instate	Out of state	Instate	Out of state
	FY2015		FY2016		FY2017		FY2018		FY2019 Q4	
DMH	78	42	74	48	57	50	50	50	63	45
DAIL	0	2	0	2	0	3	0	1	0	2
DCF	184	108	179	114	170	83	103	95	184	93

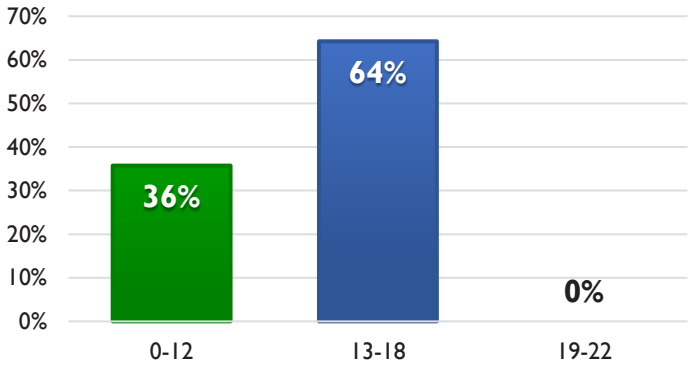
In-state versus Out-of-state Placement Count by Year

This chart represents the total number of in-state and out-of-state placements by funding department and by fiscal year. Children/youth who were placed in more than one facility or had a custody change in a fiscal year are duplicated in the count.

STATE DEMOGRAPHICS

The following charts show additional demographics of the children/youth referred to residential assessment or treatment as well as information about their time in residential treatment settings.

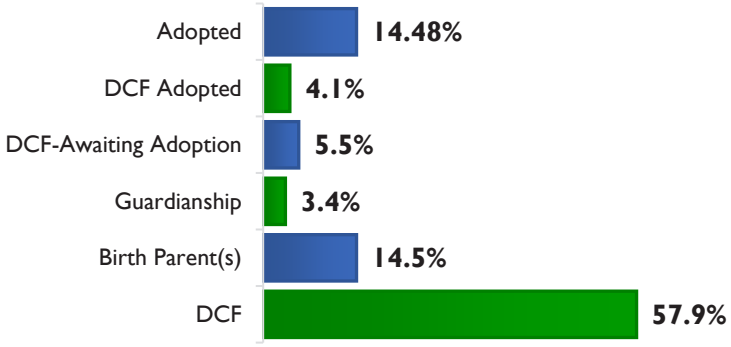
Percentage by Age Groups



Age Groups

This shows the unduplicated number of children in the identified age ranges at time of admission into the current residential program. Tracking age ranges can help with looking at needs in the system of care.

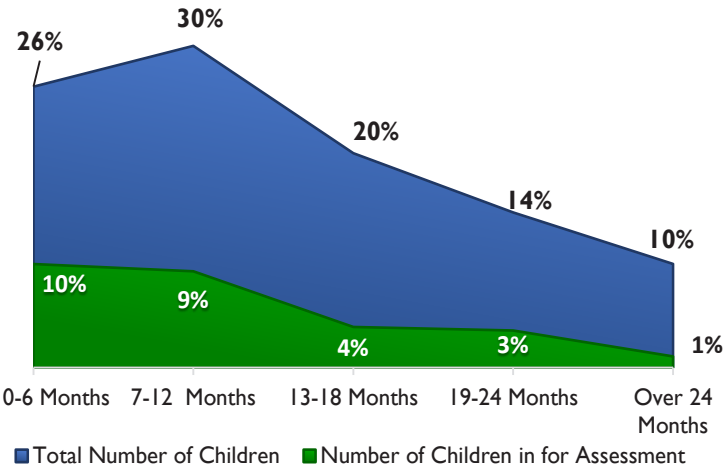
Custody



Custody

The State Interagency Team and CRC have been interested in the rates of residential treatment among children/youth who experienced adoption, guardianship, and State's custody following adoption.

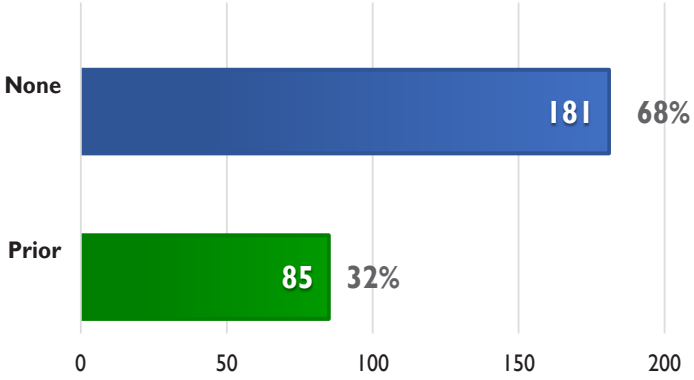
Length of Stay



Length of Stay

Length of stay is calculated based on each child/youth's days between admission and discharge (or current duration if the youth is still in the program at the time of analysis). This represents the current episode of residential care and does not show total length of out-of-home stays for youth who may be in more than program over time. Children in assessment programs tend to have shorter lengths of stay.

Children with Prior Residential Placement



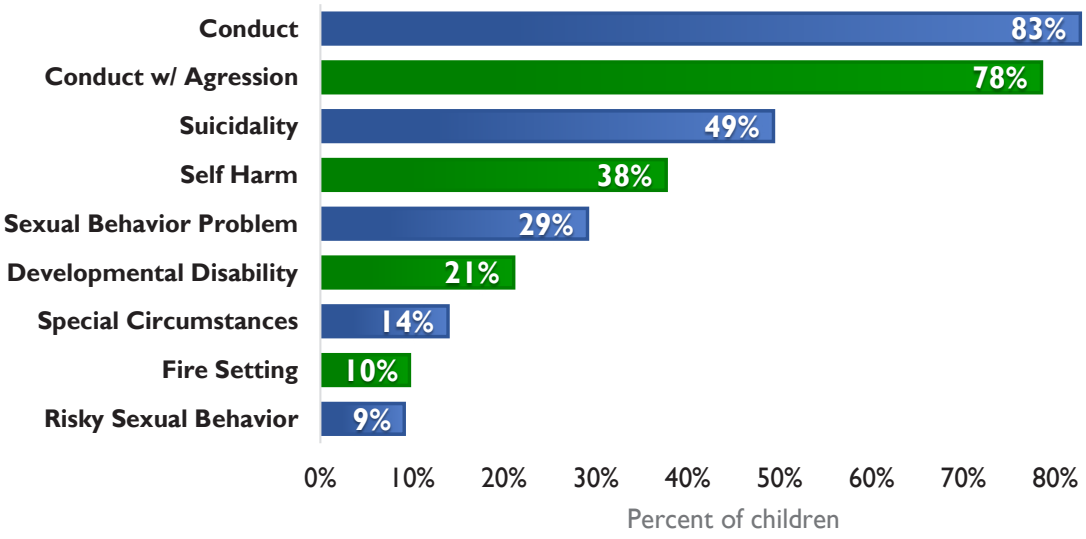
Prior Placement

This is the unduplicated number of children/youth who had any prior residential admission (to licensed residential programs including "micro" or staffed homes, not foster care) when vanother residential program vary and may indicate transition from assessment to treatment or a transition to a program to better meet the needs of the child. In any case, tracking the number of youth who are in more than one residential program can be informative about the system of care.

STATE PRESENTING NEEDS

The following charts show additional demographics of the children/youth referred to residential assessment or treatment as well as information about their time in residential treatment settings.

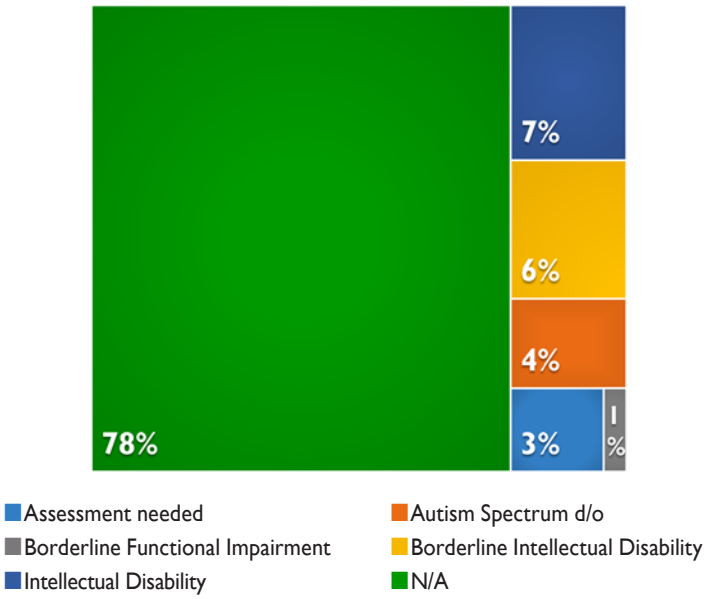
Presenting Needs Among Children in Residential Programs FY19



Presenting Needs

The CRC captures the presenting needs among children referred for residential assessment/ treatment to better understand the clinical needs within the system of care. Children may have more than one presenting need and are counted in each respective measure.

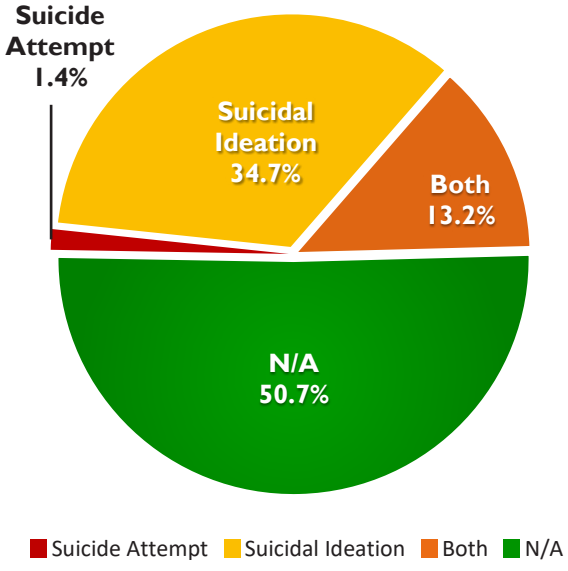
Developmental Disabilities



Developmental Disabilities

This chart shows the percentage of children with the presenting need of developmental disability broken down into more detail for Intellectual Disability, Autism Spectrum, Borderline Functional Impairment, Borderline Intellectual Disability, DD assessment needed, or no disability.

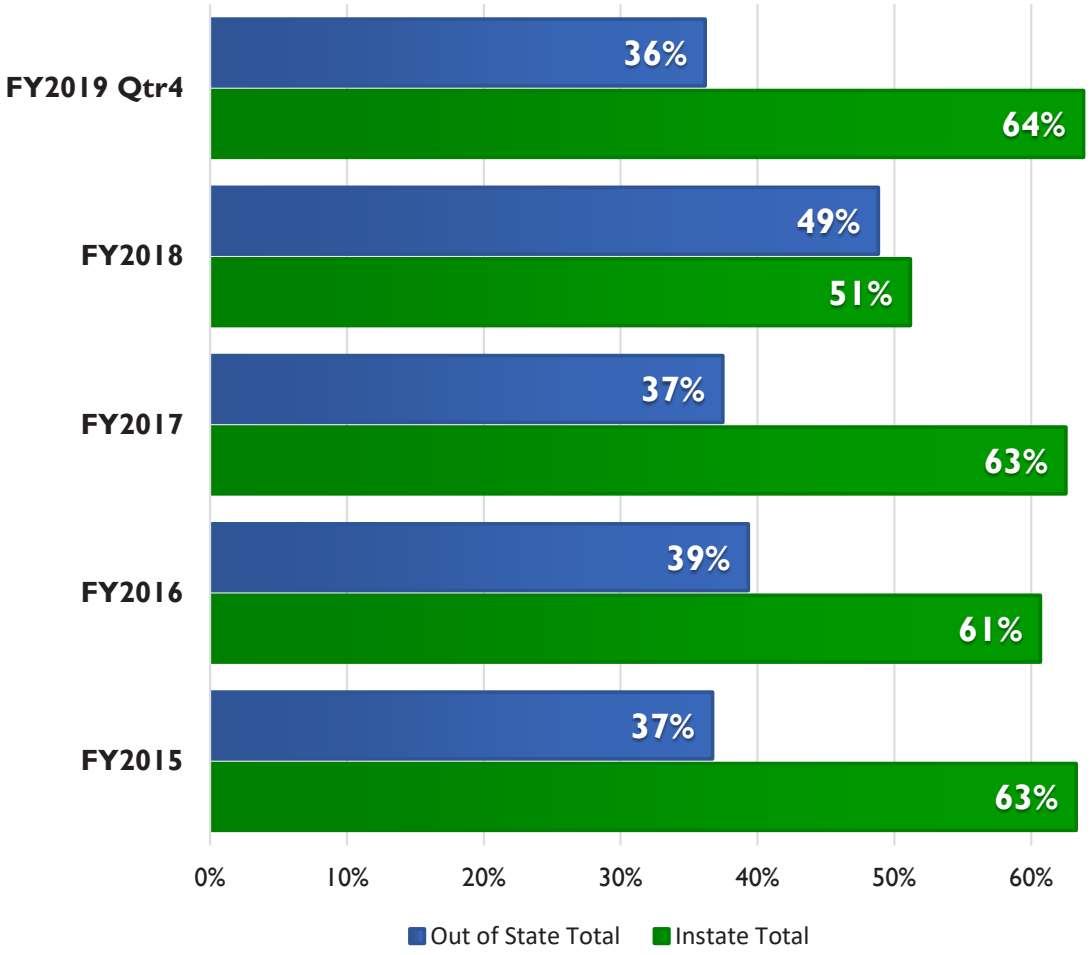
Suicidality



Suicidality

This chart shows the percentage of children with a presenting need of suicidality broken into more detail for suicidal ideation, suicide attempt, both, or none.

PERCENT OF IN-STATE VERSUS OUT-OF-STATE PLACEMENTS



Statewide

this chart represent the breakdown of in-state placements compared to out-of-state placements by fiscal year. If a child/ youth was placed in more than one program in a fiscal year, they are represented more than once.

Department of Mental Health
FY 20 BAA Narrative

Forensic Evaluation Cost Increases

Gross: $55,000 GF: $25,372

The cost of psychiatric forensic evaluations has increased significantly since FY 18. DMH is statutorily required to provide Forensic evaluations as ordered by the court and the volume of these requests has increased 24% over the past year.

Increase in Medicare Revenue

Gross: ($0) GF: ($230,650)

VPCH has several funding sources. One of those sources is Medicare and other insurance billings. These funds are accounted for in a special fund that is not specifically Medicaid, Federal or General Fund. In FY 19, DMH was able to recognize a significantly higher amount than originally projected.

Child and Youth Residential Programs

Gross: $947,333 GF: $437,779

DMH has an ongoing pressure in PNMI (private non-medical institutions – residential treatment for children). This pressure is due to many factors, but primarily DMH has seen an increase in the acuity of clinical need for children and youth. Due to increased stressors impacting family environments (including adverse family experiences such as opioid use, parental mental health challenges, and difficulty managing a child/youth's challenging behaviors) has contributed to increasing acuity of needs that are not able to be met in the community. For example, of the youth who were admitted into a residential treatment program in FY19 through DMH funding: 40% had referral concerns related to self-injurious behaviors; 38% had suicidal ideation while an additional 15 % had suicidal ideation plus a recent suicide attempt; 17 % had sexually reactive behaviors; and 40% had conduct problems (e.g. violations such as stealing, damage to property) while 38% had conduct problems with aggression towards others. (Most youth exhibit more than one of these identified behaviors at referral.) DMH has also seen an increase in referrals from at-risk populations like LGBTQ youth or children who have been adopted -- which can increase the need for specialized treatment, and sometimes has increased the length of stay in residential treatment.

These acuity concerns, coupled with staffing challenges, and decreased risk tolerance in communities due to threats of violence or self-harm has increased the demand for residential services. When the community-based array of clinical and support services has not been able to adequately address the clinical needs, children may wait in EDs, crisis beds or inpatient units while being referred for residential treatment. DMH continues to prioritize the use of effective in-state programs in order to maximize the ability of families to actively participate in treatment. However, as the number of beds has decreased, the daily rates for many in-state programs have increased through the PNMI rate setting process due to acuity of needs. DMH has also authorized the use of 1:1 staffing (at an additional cost) for short periods to support a positive transition or maintain a placement during a time of high behavioral challenges.

However, when the in-state residential programs are unable to serve the children/youth referred due to either lack of available openings or due to acuity of the youth's needs, DMH must use out-of-state

programs. While in general the out-of-state programs have lower daily rates because they are larger and have greater economy of scale, some of the programs that serve youth with intensive clinical needs have high daily rates.

Our children's clinical care management team uses clear procedures and guidelines with clinical criteria to determine medical necessity for residential treatment and provides technical assistance to schools, communities, families and Designated Agencies (DAs) around working together to explore options to meet the needs of the child in the community. As the need for residential treatment has increased, the Children's Care Management Unit has worked hard to support and prioritize meeting the needs of clients in their homes and communities.

However, when children or youth are determined to meet the medical necessity criteria for residential treatment, the DMH is required to provide that level of care under the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Determinations adverse to the request of the family are sometimes met with appeals. In order to fulfill the EPSDT mandate to provide medically necessary services to address or ameliorate a child/youth's identified mental health needs, we fund the necessary residential treatment for children in programs in-state and out-of-state.

As of 10/24/19, DMH had funded 64 children and youth in residential treatment since the beginning of the fiscal year. This number will increase in the remaining 3 quarters as youth are transitioned in and out of residential treatment. Cost factors also impact residential programming, for example the overall average daily rate for residential providers in-state and out of state increased 18%.

Finally, while our request is in response to the increased need for residential assessment and treatment, PNMI also funds the short-term children's crisis stabilization beds at Howard Center; however, these are accessed by local crisis teams following specific protocol. DMH does not approve the initial placement; crisis teams are authorized to approve admission for these settings. This represents around $1M of the overall DMH PNMI spending. As this program has been used less for DCF-funded children, DMH has been increasingly responsible for the costs. Each of the last three fiscal years, Howard Center has also requested extraordinary financial relief (EFR) which DMH is unable to budget for in advance. The EFR requests under the PNMI rules were driven by the provider's need to cover costs that are not covered due to 1) the PNMI rates being based on 2 years prior spending history, 2) commercial insurance pays lower rates than Medicaid and the rate does not cover costs, and 3) Medicaid rate increases to the DAs did not apply to residential or crisis stabilization programs, and 4) on-going struggles with staffing shortages, which has impacted utilization. This is also an issue with other residential PNMI providers. In the past 2 years, residential providers have also asked for EFRs and others have recently indicated they will be submitting requests.

Inpatient – Level 1 Cost Settlements

Gross: $400,000 GF: $184,520

RRMC: ($164,144)
BR: $564,144

Act 79 requires "reasonable actual" reimbursement of costs for the Level I hospitals. There have been inflationary factors such as contracted Doctors and Nurses which have significantly impacted the daily cost of the Level 1 units at both Brattleboro Retreat and Rutland Regional Medical Center. The impact to RRMC is negative in FY 20 because DMH is owed funds back from a previous year's cost settlement.

This also captures the retroactive rate increase for the Brattleboro Retreat based on the cost settlement period ending 12/31/2018. This rate is effective 1/1/2019 and establishes the new rate going forward.

Inpatient – CRT Cost Increases

CRT Retroactive to July 1, 2018 - Gross: $1,120,137 GF: $516,719
CRT Cost Increase beginning 11/1/2019 – Gross: $509,398 GF: $234,985

DMH is responsible to ensure the payment and inpatient care for those individuals who are identified and eligible for Community Rehabilitation Treatment (CRT) services. This funding reflects a rate increase to align with other adult inpatient rates paid though DVHA. The DVHA rates were increased in FY19, however the CRT Inpatient Rates were not increased.

UVMMC Fellowship Grant Savings

Gross: ($45,000) GF: ($20,759)

DMH grants funding to support an innovative training program in child psychiatry administered by the Vermont Center for Children, Youth and Families of the University of Vermont's College of Medicine and The University of Vermont Medical Center. DMH has been working with Dr. Hudziak around how UVMMC can assist in supporting this effort, and that work has resulted in the University agreeing to increase its ongoing funding of the program by $45,000.

One-Time Savings from Delayed Implementation of Adult Enhanced Plans

Gross: ($500,000) GF: ($230,650)

In FY 20, the Legislature appropriated additional funds to support development or enhancement of community living programs that support and maintain individuals in the community, avoiding unnecessary hospitalization. The payments directly impact a small cohort of the CRT population, all of who have significant histories of lengthy and repeated hospitalizations, and who may have had interactions with the criminal justice system or ongoing, challenging behaviors resulting from their mental illness. Expansion of these community living programs include the MyPad model, staff intensive residences for multiple clients and other individualized community wrap plans that are inclusive of housing and staff.

Many adult enhanced plans and capacity were already developed, and the funding allowed them to start providing services to some individuals, while other plans were in the development process. Due to the complex nature of these individuals there are several factors that influenced DMH's ability to have the plans and capacity come to full fruition since the funds were made available. Securing appropriate physical sites and hiring of a dedicated workforce can take time, further the community providers receive specialized training to work with this acute population. The final piece that can delay the implementation of these plans and capacity is that each of these plans are voluntary in nature and the specially trained staff have to build a relationship with their assigned individual in order to help get them out of the hospital and willing to work with these specially trained community providers. While these funds are

necessary to continue to support individuals in communities, the delayed implementation of some of the plans will allow DMH to realize savings in FY 20. DMH expects to fully utilize this funding going forward.
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AHS/AOA changes:

Transfer Howard Center Jarrett House Program to DMH (AHS Net-Neutral)

Gross: $101,243 GF:$ 49,261

This is to move funding for the Howard Center crisis stabilization program (aka Jarrett House) from DCF to DMH. While this had been a shared resource with funding from both DMH and DCF based on utilization, DCF will no longer use this program beginning 1/1/2020.

Adjustment to DA Increase – Move Funds to DAIL

Gross: ($239,994) GF: ($110,709)

In FY 20, Legislature appropriated funds to increase payments to the Designated Agencies and Specialized Service Agencies. This increase was provided with a 50%/50% split between DAIL and DMH with the intention of allocating the funds proportionally to each department. This is to redistribute the funds appropriately.

DMH FY 20 BAA Summary

	Gross	**GF**
General Fund:	$4,749	$4,749
Special Fund:	$500,000	$0
Medicaid GC Fund (Including Investment):	$1,843,368	$850,346
Total DMH Request:	**$2,348,117**	**$855, 095**