DMH Talking Points
FY 20

Salary and Fringe Increases

Gross: $579,582 GF: $241,262

Annualization of the FY18 salary and related fringe changes per the following:
Salary: $142,392
Retirement: $465,086
Other Fringe: ($27,896)

Eliminate Sheriff Supervision (BAA Item)

Gross: ($582,029) GF: ($268,490)

This reduction eliminates only the sheriff supervision taking place in hospital Emergency Departments. A large portion of the money we pay under the sheriff's contracts is for supervision in emergency departments (ED) vs transportation. We are legally required to provide transport, we are not for supervision – it was something DMH started doing after Irene to help the hospitals. However, it has been an ongoing and increasing cost for DMH's budget. Supervision simply provides an additional body other than hospital staff to keep eyes on a person. A hospital's ability to manage the dysregulated behavior of a patient who is waiting for an inpatient psychiatric bed varies from hospital to hospital. This may be due to the need to maintain a safe surrounding, availability of support resources, or security services at the hospital

Per Centers for Medicare and Medicaid Services (CMS) standards non-hospital personnel may not put hands on, restrain, contain in any way, or otherwise stop a person from leaving the ED. CMS is very clear that patients in the hospital are the sole responsibility of the hospital. Should a sheriff intervene, which unfortunately happens, Licensing and Protection (L&P) can and does investigate. At least two hospitals have had findings against them and one is working on a corrective action plan to avoid losing their CMS certification. Using Sheriffs in EDs continues to expose the hospitals to increased risk of further CMS violations. Should they find the hospital violated CMS standards, the hospital's certification may be at risk. Further, some hospitals have built psychiatric-specific supports in their emergency departments allowing reduced reliance on sheriff supervision, which may have contributed in an overall decrease of sheriff supervision use in 2018.

The Department of Mental Health is studying security protocols in emergency departments to ensure the safety of patients and hospital staff as well as compliance with federal regulations. The process includes consultation with the Vermont Association of Hospitals and Health Systems; Vermont Care Partners; the Department of State's Attorneys and Sheriffs; an individual who provides peer support services in an emergency department, appointed by Vermont Psychiatric Survivors, as well as the Division of Licensing & Protection in order to understand how the federal regulations are applied and if there could be changes allowable between hospitals and sheriffs.

Sheriff Supervision Costs
FY18
By Hospital

Hospital	Total Cost	Number of Invoices
BMH	$25,871.98	5
COPLEY	$77,838.75	14
CVMC	$165.00	1
GIFFORD	$38,190.77	8
MT ASCUTNEY	$22,387.65	6
NMC	$27,370.18	5
NORTH COUNTRY	$28,115.85	10
NVRH	$68,206.25	13
PORTER	$134,924.56	23
SPRINGFIELD	$135,017.85	19
SVMC	$6,395.03	6
UVM-MC	$2,665.00	2
VPCH	$633.07	4
TOTAL	$567,781.94	116

Data based on invoices sent from Sheriff Departments to the Department of Mental Health. Supervision includes supervision in Emergency Departments and Court Hearings (VPCH).

Physician Contract with University of Vermont Medical Center (UVMMC) (BAA Item)

Gross: $214,558 GF: $98,976

DMH re-negotiated the UVMMC contract; and UVMMC required salary increases for their Psychiatrists. With the recent retirement of some of the Psychiatrists providing services to VPCH and MTCR, UVMMC has had difficulty hiring into these positions due to the statewide shortage of Psychiatrists. Therefore, it was necessary to increase salaries for recruitment and retention purposes by bringing their salaries more in line with those of hospital psychiatrists in the region. This is to cover the cost of those increases.

Recognition of additional Medicare Revenue for VPCH (BAA Item)

Gross: $0 GF: ($345,975)

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. When VPCH opened DMH did not have history of Medicare and other billings, therefore we estimated the revenue to be $423,068. Over the last couple of years, the revenue has averaged ~ 1.2M. This is to recognize the additional revenue being received, thus reducing the need for GC Investment funds.

Increase to VPCH Operating Costs (BAA Item)

Gross: $750,000 GF: $345,975

$750,000 is needed to cover additional operating expenses at VPCH, mostly due to traveling nurses. VPCH continues to struggle in recruiting classified nurses despite nurse salary upgrades from two years ago given a nursing shortage nationally. There is still need for travelers due to vacancies as well as nurses being out on workers comp.

Contract Reductions

Gross: ($155,979) GF: ($74,523)

This is a reduction to children's psychiatric consultation to primary care as well as savings we are projecting from the original budget for Pharmacy services at VPCH. In the original contract with Copley for pharmacy services, there was a Pharmacy Director, 1.3 Pharmacists and 2 Pharmacy Technicians. Actual experience indicates the need for 1 Pharmacy Director, 1 Pharmacist and .9 Pharmacy Technician or a reduction of 1.4 FTE overall, which is what is in the current contract with DLeigh.

Internal Service Funds (Workers Comp)

Gross: $176,689 GF: $82,239

Annual increase to Workers Compensation Insurance for DMH.

Operating Internal Service Fund Changes

Gross: $302,858 GF: $144,174

Annual increase to internal service funds such as Fee for Space, Insurance, DII, Finance and Management Systems (VISION), HR, etc.

Operating Expense Savings

Gross: ($17,054) GF: ($51,724)

This is savings related to operating expenses. After thorough review of DMH operating expenses and funding sources from the prior fiscal year and current projections, we feel strongly that we can obtain these savings.

HUD Funding Impact – (HC Branches)

Gross: $120,076 GF: $120,076

Four of the DA's have lost all or most of their HUD funding by the end of FY 18. Howard Center had two programs that lost their funding at different times, Branches and Safe Haven. DMH secured replacement funding for all of the programs except Branches in previous years. In FY 20, this program will have lost all of its HUD funding, therefore, we are asking to replace those funds with General Fund dollars.

Child/Youth Residential (BAA Item)

Gross: $1,548,085 GF: $$822,617

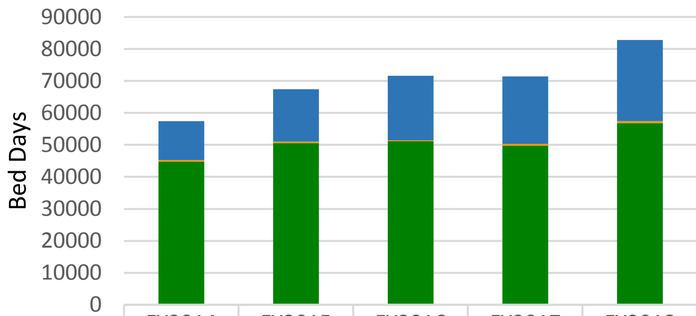
DMH has an ongoing pressure in PNMI (private non-medical institutions – residential treatment for children). Due to many factors, but primarily increased family challenges (including adverse family experiences such as opioid use, parental MH, and difficulty managing a child/youth's challenging behaviors), decreased access to community-based services due to staffing challenges, and decreased risk tolerance in communities due to threats of violence, the demand for residential has increased. DMH has seen an increase in the acuity of clinical need in the children and their families. When the community-based array of clinical and support services has not been able to adequately address the clinical needs, children are referred for residential treatment.

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 with expecting schools, communities, families and Designated Agencies (DAs) to work together to explore options to meet the needs of the child in the community. 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. While DCF has seen a reduction in their residential utilization rates, DMH's experience is that children and their families still have very high needs that are addressed through the DMH system (see charts below).

Additionally, many PNMI programs bring forward requests for rate adjustment or extraordinary financial relief through the PNMI rule process. When granted by DRS in coordination with DMH and DCF, these fiscal increases are in addition to caseload pressures and are not budgeted for in advance.

Lastly, while our PNMI funding request is in response to the increased need for residential assessment and treatment, it is noted that one of the short-term crisis stabilization programs falls under PNMI rule and also contributes to the pressure on these funds; whereas the two other child/adolescent crisis programs are not under PNMI. While the crisis stabilization program is PNMI rate set and thus contributes to the PNMI funding pressures, these crisis beds are accessed by local emergency services teams following specific protocol. DA emergency services teams are authorized to approve up to 10 days in this setting; DMH does not approve the initial placement. The DMH funding for children not in DCF custody who access this crisis program represents around $1M of the DMH PNMI spending.

Total Residential Bed Days by Department per Fiscal Year Through FY18

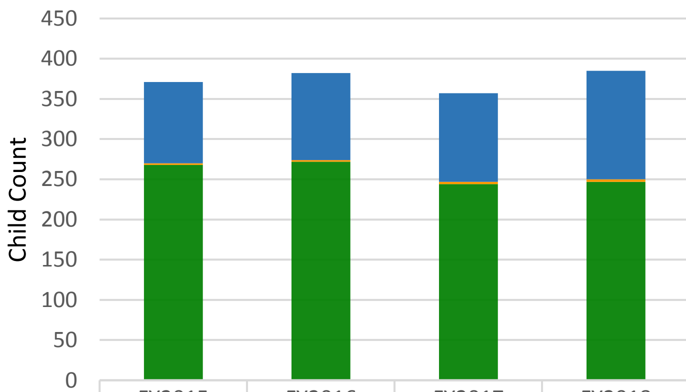


	FY2014	FY2015	FY2016	FY2017	FY2018
DMH	12105	16341	20145	21047	25318
DAIL	557	511	289	623	598
DCF	44711	50539	51144	49725	56869

State Fiscal Year

unduplicated count

Total Child Count in Residential by Department per Fiscal Year Through FY18



	FY2015	FY2016	FY2017	FY2018
DMH	101	108	110	135
DAIL	2	2	3	3
DCF	268	272	244	247

State Fiscal Year

unduplicated count

<u>Room & Board Phase Down</u>

Gross: $0 GF: $594,892

CMS is requiring the State of Vermont to phase down payments toward disallowed room and board expenses beginning on January 1, 2019 by 1/3 of the total each calendar year through 2021. Room and board costs are associated with children/youth who meet criteria for Intensive Home and Community Based Services and receive treatment in therapeutic foster homes or small staffed living homes in the community.

Adult CRT Enhanced Plans

Gross: $534,810 GF: $246,708

These funds 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 whom 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. These plans include but are not limited to the scale up of the MyPad residential program; which is a housing model that provides on-site treatment and supports to individuals living independently.

CRT enhanced plans support timely discharge planning and aftercare for individuals who no longer require hospital services. Typically, enhanced plans are more cost-effective and less restrictive than an inpatient setting with an unnecessarily longer length of stay. These requested budgetary monies will fully fund programs for individuals who have limited discharge options due to their histories and current clinical presentations. Each of these individuals have spent well over a year either in Level 1 beds or at Intensive Recovery Residences (IRRs), or back and forth to both with little to no opportunity to access additional treatment, recovery and care options. IRRs are not designed to be permanent residences, their target length of stay is between 6 months and 18 months, and currently the state average length of stay at an IRR is 283 days, or just over 9 months.

If the enhanced plan payments were unavailable, we would continue to see an increased number of people needing Level 1 inpatient services with few community aftercare options until full inpatient stabilization was achieved. Ongoing demand for the limited number of Level 1 beds would have a direct impact on people's ability to access appropriate levels of care in a timely fashion and the volume and length of stay of people waiting in Emergency Departments for placement.

This budgetary request will allow us to fully fund these programs, which will in turn directly impact flow in the mental health system.

Other Grant and Contract Reductions

Gross: ($128,909) GF: ($63,409)

This reduces our contracts by underutilization of TBI (Traumatic Brain Injury) services as well as an agreement with Copeland Center for Wellness.

DMH strongly supports advocacy and peer work in our system. In order to obtain necessary savings, DMH proposed to eliminate a contract with Copeland Center for Wellness versus alternative reductions that would have negatively impacted and de-stabilized our non-profit advocacy partners programs that provide an array of mental health services and supports. This contract supports Wellness Recovery (WRAP) training through the Copeland Center which is a national organization. DMH is reviewing the possibility of embedding some of this work into other grants or contracts.

Allocation of AHS-wide Grants reduction plan (AHS net-neutral) (BAA Item)

Gross: ($1,034,713) **GF: ($477,313)**

This is an AHS-wide grant reduction initiative to implement best practices around grant management. While DMH has an unachieved target, we are continuing to search for opportunities for savings, and will address at closeout if necessary. DMH is committed to continuous quality improvement of grant oversight and monitoring critical metrics of progress towards outcomes.

AHS/AOA changes:

Success Beyond Six (SBS) - Locally matched (BAA Item)

Gross: $17,900,000 GF: $8,257,270 (locally matched)

Overall program growth for the SBS program, which includes behavioral interventionists, school-based clinicians, and funding for specialized schools, is anticipated to be approximately $16.2M more than the fy19 base appropriation, bringing the program total to just over $70M. Match is paid for by the local schools.

The children's system is experiencing pressures in community-based, inpatient, crisis stabilization, and residential treatment programs, so the needs for children and families appear to be increasing across our system, including within schools. Youth Risk Behavior Survey (YRBS) data indicates that 19% of middle school students show signs of depression and 18% have had serious thoughts of suicide; 25% of high school students show signs of depression, 16% have hurt themselves on purpose, 11% have made a plan and 5% attempted suicide. Although overall student enrollment has decreased, VT has the highest rate of identified SED in the nation and schools are requesting mental health supports so that students can remain in the classroom and school setting, while also bringing MH expertise and consultation to their school-wide efforts to address all students' needs.

Applied Behavior Analysis (ABA) funding back to DVHA for NCSS (BAA Item)

Gross: ($1,394,200) GF: ($643,144)

This funding was added to the NCSS (Integrating Family Services) IFS bundle over a three-year period beginning in FY 16. DVHA has created a bundled payment structure to pay for all ABA services beginning July 1, 2019. This is a net neutral transfer to DVHA.

Move Children's Individual Service Budget (ISB) Funds back to DCF (BAA Item)

Gross: ($1,500,000) GF: ($691,950)

With the DMH payment reform effort, the Medicaid services being provided by the DA system for the children and youth in DCF custody will be included in the Medicaid bundles. This includes the Micro-residentials as well as individual fee for service. The remaining funding is being returned to DCF for a direct contract to Laraway for services similar to those previously provided through ISBs.

Agency of Digital Services (ADS) true-up from AHS Central Office (BAA Item)

Gross: $394,134 GF: $197,067

This is a true-up of ADS cost associated with the Department of Mental Health.

DVHA to DMH for Payment Reform (BAA Item)

Gross: $5,592,050 GF: $2,548,062

This is the cost associated with Mental Health services currently being paid to the Designated Agencies through DVHA. DMH has gone through an extensive payment reform effort, which began on January 1, 2019 to bundle adult and children's mental health services. Included in these bundles is the dollars associated with the DVHA spend for mental health services through the designated agencies.

Level one New Beds (Early Spring 2020 start 12 beds)

It is anticipated that the renovations at the Brattleboro Retreat will be completed in the spring of 2020 for 12 new Level One beds, however, the firm opening date is still unknown. The funding level is zero due to the unpredictability of the start date and true need for operating expenses. The estimated operating costs based on 6 months of operation are $2,584,200, and assumes $1,475/day multiplied by 80%, which is the estimated Medicaid portion. The remaining 20% of the funding will come from other insurance or private pay. DMH anticipates requesting operating funds in the FY 20 BAA when we have more information on the projected start date. DMH will also include a base budget request for the full annualization of operating costs in the FY 21 budget.