State of Vermont AGENCY OF HUMAN SERVICES

OFFICE OF THE SECRETARY
280 State Drive
Waterbury, Vermont 05671

TO: **Senate Committee on Appropriations**

FROM: **Michael K. Smith, Secretary, AHS**

DATE: **June 19, 2020**

SUBJECT: **AHS Feedback to the House-Passed version of H.965 – An act relating to health care- and human services-related appropriations from the Coronavirus Relief Fund**

In your review and mark-up of H.965, please consider the following section-by-section feedback in response to the House-passed version of H.965. Across the board, provider groups indicate that without further financial assistance, providers and organizations that provide essential services may be forced to close. Our goal is to work with the General Assembly to provide critical financial relief to Vermont's health care and human services providers in the wake of the COVID-19 pandemic.

Toward that end, I'm requesting that the Health Care Stabilization Program funding be restored to the Governor's proposal of $375M to support these critical providers that were negatively impacted by the pandemic. Considering spent/obligated funds and funds appropriated in other bills, there is a difference of roughly $50M. See the table below.

	Include other HC approps	
Other Appropriations	16,400,000	Adult Day, EMS, CIS, Community Health Inv, Health Disparities
House Proposal HC Stabilization	250,570,000	
Spent or Obligated per JFC approval	58,035,119	To date spent/obl, July prosp. payment, Brattleboro Retreat
TOTAL	325,005,119	
Governor's Proposal	375,000,000	
Delta to Gov Proposal	49,994,881	
Potential New House Amount	300,564,881	

AHS Staff Resources: AHS cannot cost allocate to our base federal programs for the work detailed in H.965 and there are no base general funds to support these staff costs. AHS is not requesting additional permanent FTEs, but funding is needed for staff not doing their normal work on existing federal programs as we respond to this health crisis.

AHS requests CRF funding to be used for direct reporting of staff time substantially dedicated to COVID activities as a fair share of allocated costs.

FEMA and Other Federal Funds: This bill does not contemplate potential FEMA or other federal sources that could offset the CRF request. AHS will continue to explore all federal funding opportunities to support Vermont in the response and recovery to the Covid-19 Pandemic.

Reporting Requirements: AHS acknowledges the importance of reporting to the Legislature and Vermonters on the relief payments made as part of the Health Care Provider Stabilization program. However, given the process the Agency implement, we requests that the reporting dates be changed to August 15, 2020 and October 1, 2020.

Section 6 – Health Care Provider Stabilization Program:

1. **As indicated above, AHS is requesting full funding of this critical program at the Governor's proposed $375M.**

2. **AHS requests that the criteria that it may consider in evaluating applicants be modified in subsection (d) (1) to add the following:** (6) Where applicable, the applicant maintains participation in value-based payments arrangements.

3. **AHS requests that the legislation not make specific funding allocations to provider types but is instead based on demonstrated need via the application process.**

AHS believes that the proposed language gives enough flexibility to develop a need-based methodology that could be uniformly applied and equitable given the stipulations for CRF distribution. However, the specific funding amounts called out in this section may conflict with the need-based methodology for determining financial relief. By having specific allocations for certain groups there may be a situation where we find that:

a. The need-based formula suggests an amount of payments to a group of providers that exceeds the amount specified in the legislation (in which case AHS would only be able to fund a smaller percentage of need for that group), or
b. The need-based formula suggests an amount of payments to a group of providers that is less than the amount earmarked for that group by the legislation (in which case AHS would not want to be required to spend the full amount on that group when unmet need may exist for other groups of providers.)

The first scenario is more likely. If we assume that need for most groups will exceed the total available funding, specifying amounts for certain provider groups could also result in a situation where one group is more comprehensively funded than another group. It is important to recognize that the financial impact of COVID-19 varies by provider type and cannot be verified without an application process. By using an approach without allocations for specific provider groups, need could be met more uniformly based on the full evaluation of need and available resources.

Finally, later sections of the bill allocate funds for providers that are also named as eligible for the Provider Stabilization Program. Since these entities may only receive funds through one need-based assessment, we recommend that the separate funding allocated for these provider types also be included in the Provider Stabilization Program.

Furthermore, applicants for assistance through the Provider Stabilization Program will not be eligible for assistance through the Coronavirus Emergency Economic Recovery Grants.

Section 7 – Community Health Investments: We request that this funding be reallocated to the Health Care Provider Stabilization Program, Section 6.

Section 8 – Addressing Health Disparities: We recognize that this work is particularly important now, as Vermont and the rest of the country reevaluate our social and public institutions to make them more just and equitable to all. The Vermont Department of Health has received an Epidemiology and Laboratory Capacity (ELC) Enhanced Detection Grant. AHS intends to use part of this tranche of money for subgrants to community organizations to engage with key communities that may be at an increased risk of COVID-19.

AHS is committed to improving health equity – but we want to make sure our efforts are not duplicative. The scope of work to be supported through the ELC grant may overlap considerably with this portion of the house bill. We should clarify our intents. If the two grants do intersect in diminishing way, we recommend this funding be reallocated to the Health Care Provider Stabilization program.

AHS/VDH agree with the premise of the language but have concern about the prescriptive language of section 8(c) requiring that the funds can be used only for "up to 10 grants to community agencies" and requiring selection of grantees "based on prior demonstrated work with the affected population…".

The provisions of section 8(c) would severely limit the state's ability to address the specific needs of these individuals within the period of allowable use of CRF funds. Groups with the greatest health disparities also lack the established social support agencies and demonstrated track records that this section mandates. Addressing the health needs of these individuals often requires non-traditional approaches that would not be allowed by the provisions of section 8(c).

Section 9 – Suicide Prevention: AHS and DMH support the intent of this appropriation, however, it is important to note that DMH has applied for a grant from SAMHSA for suicide prevention related to the COVID crisis. If the grant is received, this CRF appropriation will not be needed. DMH anticipates receiving notification shortly.

Section 10 – Peer Warm Line: AHS and DMH support his appropriation and will be able to implement as written. The appropriation is based on the budget that Pathways provided to operate its warm line for 24 hours a day, 7 days a week through the end of December. The warm line is an essential component of mental health crisis services for Vermonters, even more so because of the COVID crisis. The need for expanded access to mental health services and supports is essential to Vermont's recovery from COVID 19 due to increased stress, anxiety, and isolation.

Section 11 – Parent Child Center Network: AHS and DCF are concerned that the bill appropriates $3.9M to the Parent Child Centers with no specific language regarding what the funds should be used for, and how they relate to COVID related expenses/impact. DCF received a request from

the PCC's at the start of COVID pandemic, requesting $5M but without a substantiation of the need or an explanation for how this funding would be used. The PCCs have received funds from the current childcare stabilization program, childcare restart stipends, and the CIS COVID EFR funds.

We are concerned that this language creates a passthrough of funding through DCF, with no articulated requirements for the corresponding grant awards. It should also be noted that the $3.9M exceeds their annual award in the PCC master grants, ($3.3M). This will be a substantial amount of funding for the PCC's to use within the 6-month period in compliance the CRF requirements. AHS/DCF suggests that the legislature add prescriptive language and performance measures with regards to the intent of these funds should they be included, and how they meet CRF requirements.

Section 12 – Childcare – Summer Camp, Afterschool Program, Restart Grants: DCF supports the desire to provide support for childcare programs. The Restart program was intended to provide programs with one-time funds for the purchasing of cleaning supplies, funding for additional staffing needs, as well as modifications to structures. Between the Restart program and the Childcare Stabilization Program, AHS has spent approximately $20M. We did not request additional funds in this area.

Section 13 – Children's Integrated Services: We request that this funding be reallocated to the Health Care Provider Stabilization Program, Section 6, with expanded language to include CIS providers. AHS/DCF supports using CRF funds to support CIS, however CIS has already moved to telehealth, and through the COVID-19 Extraordinary Financial Relief process, many of these associated startup expenses have been covered.

Section 14 – Infant Supplies: AHS/DCF recognizes the need to support families with infants, especially related to the COVID-19 crisis. We support the basis of this appropriation but recommend that it be given to the Vermont Foodbank in Section 15 for the purpose of supporting the diapering needs of low income and vulnerable Vermonters during the COVID pandemic.

Section 15 – Charitable Food System: This language was added during the House process, and not requested by AHS. If the appropriation remains in the bill, AHS believes it is a better fit to be appropriated at DCF. DCF has established relationships and grant programs with the Vermont Foodbank and would be willing to administer these funds utilizing existing mechanisms thereby reducing administrative and operational burdens.

Section 17 – Food Distribution to Older Vermonters: DAIL has received Title III funds for the Area Agencies on Aging and Vermont Center for Independent Living for food distribution via Meals on Wheels. These funds would be on top of the Title III funds and at this time we have not identified that there is a need for this appropriation.

Section 18 – Adult Day Programs: AHS/DAIL supports the continuation of support to Adult Day providers and believe it could be included in Section 6.

Section 19 – Supports for New Americans: AHS supports this appropriation and believes the program can be implemented as written. It will be critical to work with these organizations to ensure that the funds are spent in a timely manner.

Section 20 – Peer Supports: We request that this funding be reallocated to the Health Care Provider Stabilization Program, Section 6. AHS and DAIL support his appropriation and will be able to implement as written via a grant to Green Mountain Self Advocates.

Section 21 – Supplemental Reach Up Assistance: AHS/DCF has concerns that the current language may not be an allowable use of CRF in terms of supplemental grants to families with children under six, and the administrative cost would be more than the appropriation of $300,000. DCF would face challenges with operationalizing this proposal, specifically to add this as an ongoing benefit would require significant IT programming changes, costing both staff time, and development costs. Furthermore, once the benefit ends, we would have to undo the programmatic changes thus resulting in further costs.

DCF agrees that low income families are experiencing significant difficulties with COVID. DCF continues to see ongoing pressures in its Reach Up budget, which will likely require an additional appropriation over what was approved in May by the JFC. However, at the time of writing this memo we have not yet had time to develop a specific plan for addressing this pressure for FY21.

Section 22 – Recovery Residences: AHS/VDH concur with the bill's intent of providing financial assistance to individuals in recovery, but more analysis needs to be done to determine if it is already covered in other areas of rental assistance being appropriated in H.966. If it has not yet been covered, we would request that this funding be reallocated to the Health Care Provider Stabilization Program, Section 6.

CC: Senate Committee on Health and Welfare
House Committee on Appropriations
House Committee on Health Care
House Committee on Human Services
Speaker Mitzi Johnson
President Pro Tempore Tim Ashe