State of Vermont
Agency of Human Services
280 State Drive
Waterbury, Vermont 05671

Report on Vermont's Institutions of Mental Disease

Act 200 of 2018

Submitted to

House Committee on Appropriations

House Committee on Corrections and Institutions

House Committee on Health Care

House Committee on Human Services

Senate Committee on Appropriations

Senate Committee on Health and Welfare

Senate Committee on Institutions

Submitted by

Al Gobeille, Secretary

Vermont Agency of Human Services

January 15, 2019 (revised January 30, 2019)

Statutory Language

Sec. 10 of Act 200 of 2018, An act relating to systemic improvements of the mental health system, requires that the Agency of Human Services (AHS) provide the Vermont Legislature an annual report each January 15 from 2019-2025 on the Agency's progress in evaluating the impact of federal Institutions for Mental Disease (IMD) spending on persons with serious mental illness or substance use disorders.

> Sec. 10. REPORT; INSTITUTIONS FOR MENTAL DISEASE
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> The Secretary of Human Services, in partnership with entities in Vermont designated by the Centers for Medicare and Medicaid Services as "institutions for mental disease" (IMDs), shall submit the following reports to the House Committees on Appropriations, on Corrections and Institutions, on Health Care, and on Human Services and to the Senate Committees on Appropriations, on Health and Welfare, and on Institutions regarding the Agency's progress in evaluating the impact of federal IMD spending on persons with serious mental illness or substance use disorders:
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> (1) a status update that shall provide possible solutions considered as part of the State's response to the Centers for Medicare and Medicaid Services' requirement to begin reducing federal Medicaid spending due on or before November 15, 2018; and
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> (2) on or before January 15 of each year from 2019 to 2025, a written report evaluating:
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> (A) the impact to the State caused by the requirement to reduce and eventually terminate federal Medicaid IMD spending;
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> (B) the number of existing psychiatric and substance use disorder treatment beds at risk and the geographical location of those beds;
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> (C) the State's plan to address the needs of Vermont residents if psychiatric and substance use disorder treatment beds are at risk;
>
> (D) the potential of attaining a waiver from the Centers for Medicare and Medicaid Services for existing psychiatric and substance use disorder services; and
>
> (E) alternative solutions, including alternative sources of revenue, such as general funds, or opportunities to repurpose buildings designed as IMDs.

This is the first annual report required under Sec. 10 of Act 200. As discussed in the report due November 15, 2018[1], AHS was required to submit a phase-down schedule of funding for Vermont IMDs, as required by CMS in Vermont's Global Commitment to Health 1115 Demonstration Waiver. In order to have adequate time to adjust our system of care strategically, AHS presented the following phase-down schedule of Federal Medical Assistance Percentages (FMP) to CMS:

2021: 95% of FMAP

2022: 90% of FMAP

2023: 85% of FMAP

2024: 80% of FMAP

2025: 75% of FMAP

2026: 0% of FMAP

The full proposed phase-down schedule is now available on the Department of Vermont Health Access' website.[2] The schedule was submitted to CMS on December 31, 2018 and has not yet been approved. We will address the specific parts of the report as required by Act 200 but recognize that there are many paths to consider depending on the outcome of decisions made by our federal partners. The full time allowed to 2026 is necessary to restructure and refinance the system in a way that prevents the most severe impacts to access and quality that would be caused by a loss of federal funding

Vermont has amended its Global Commitment to Health 1115 Demonstration waiver to receive authority to pay for IMD treatment of primary substance use disorders (SUD). Therefore, the IMD phasedown of federal funds required by STC 87 of the State's 1115 waiver is limited to the following:

Facility	Type and Target Group(s)	Treatment Focus	# of Beds	SFY18 Gross Expenditure
Lund Home *Burlington*	Residential treatment for pregnant and parenting women with children under 5 years old	Psychiatric/SUD	26	$2,349,849
Brattleboro Retreat *Brattleboro*	Inpatient stabilization for adults	Psychiatric, Co-occurring SUD	89	$13,780,260
Vermont Psychiatric Care Hospital *Berlin*	Inpatient stabilization for adults under the care and custody of DMH	Psychiatric, Co-occurring SUD	25	$22,438,553

[1] https://legislature.vermont.gov/assets/Legislative-Reports/ACT-200-IMD-report-update-11-15-18.pdf
[2] http://dvha.vermont.gov/global-commitment-to-health/1cms.final-phasedown-report-12-31-18.pdf

IMD settings are an integral part of our current mental health treatment continuum of care. The loss of IMDs would negatively impact an already stressed system with increased demand. High levels of wait times in emergency departments across the state reveal that there are currently not enough beds throughout our system of care. If the State were to lose FMAP for IMDs faster than outlined in our request to CMS, our primary concern would be that decisions would need to be made about the future system of care in Vermont in a state of emergency. Our examination of alternatives to IMDs within the system of care raise serious political, philosophical, and financial implications that would require robust stakeholder engagement and considerable strategic planning by the State, providers, and the legislature to fully explore.

Even with federal funding still available, the current psychiatric bed capacity is not adequate to meet the demand. A September 2016 policy brief, compiled by the Treatment Advocacy Center (TAC), suggests that the most commonly cited bed target is 40-60 psychiatric beds per every 100,000 residents.[3] Using this range, Vermont's adult inpatient bed target would be between approximately 200 and 300 beds statewide. While the TAC report focuses on public psychiatric bed reductions, the bed formula for resource needs – whether it is specifically hospital beds or some other treatment environment option – is still worthy of consideration. However, at the low end of this range, Vermont faces significant challenges in emergency department wait times for inpatient care, and bed occupancy rates are 5-10% above the practice standard of 85%. To further reduce bed capacity would result in substantial reductions in timely access and leave Vermont without a system to adequately serve people in psychiatric crisis. More information about the potential options available to maintain inpatient beds can be found in the phase-down plan submitted to CMS.

Significant administrative, facility, and geographic shifts in the delivery of mental health from the status-quo to a post-IMD model are necessary to avoid the most significant burdens this reduction in funding will place on Medicaid beneficiaries and the system of care. Vermont's proposed phase down schedule considers the extensive amount of time and resources that will be necessary to adequately plan and implement such large-scale change.

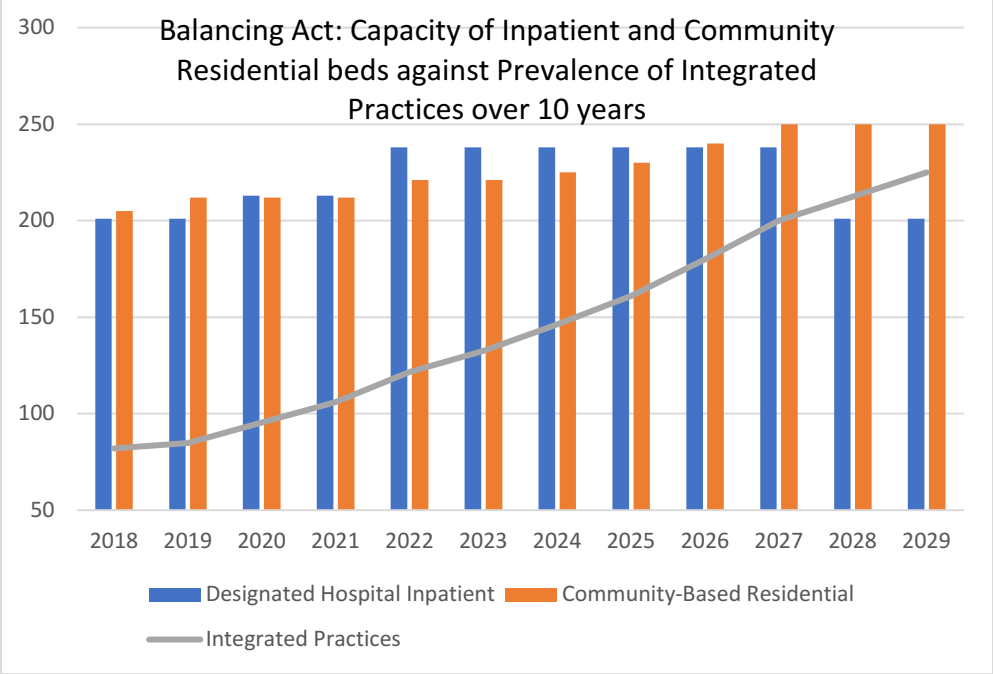
Consistent with a collaborative network approach between hospitals and community-based programs, the gap in bed capacity could potentially be addressed through more robust investments in the expansion of an array of

[3] Psychiatric Bed Supply Need Per Capita, The Treatment Advocacy Center, September 2016, retrieved Feb. 28, 2018 http://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3696

residential support models in the community. However, in line with a complete system of care, Vermont will need to ensure there is a place for all individuals experiencing a psychiatric crisis. If the state is not successful in receiving a waiver (see below) and federal funds continue to phase down, we will very likely see overall inpatient bed capacity reduced.

Further, as we work towards our goals of an integrated and holistic health care system, the need for inpatient level of care may be reduced over time. A visual of this concept is provided below for illustration and discussion purposes. The premise is that inpatient capacity must grow initially, but that additional capacity in community residential levels of care and expansion of integrated care approaches may alleviate the need for inpatient level of care over time. Prevention and health promotion activities should also help decrease the number of Vermonters who find themselves in need of such levels of care.

Inpatient levels of care are illustrated to be stable for several years while the growth and impacts of improved community capacity, integrated care approaches, and prevention activities are evaluated for impact. For purposes of this illustration, the projected outcome is that changes in community residential and integrated care delivery are impactful such that inpatient capacity may be reduced to 2018 levels after 10 years. This is not a foregone assumption by AHS but is proposed as the framework of a vision that is worth further exploration.



Waiver Opportunity

Vermont intends to pursue an amendment to its Global Commitment to Health 1115 Demonstration waiver to receive authority to pay for short-term residential treatment services in an IMD for individuals with severe mental illness[4]. At this time, we have requested legislative authority to pursue such a waiver as part of the Administration's request for the FY2019 budget adjustment. Similar to the Substance Use Disorder (SUD) IMD 1115 waiver opportunity, Vermont is already well-poised to take advantage of this change in federal policy.

Vermont is encouraged by the waiver opportunity, but concerns remain that the 30-day statewide average length of stay restriction will continue to cause funding challenges for IMDs. Although a 30-day length of stay limitation falls within evidence-based best practice for the treatment of substance use disorders, and therefore is a rational guardrail for the SUD IMD 1115 demonstration, no such length of stay best practice exists for mental health treatment. Rather, the medically necessary length of stay for psychiatric inpatients varies significantly based on the complexity of the patient's illness.

Conclusion

IMDs are currently one of the essential components of Vermont's current psychiatric system of care. The elimination of IMDs due to a loss of federal funds would have significant impacts to the system of care. The phase-down plan proposed to CMS allows AHS and our partners the time necessary to evaluate and carefully prepare for the elimination of IMD funding. It will also provide for more time to study and continue to implement the most effective and high-quality care-delivery models to serve these populations.

AHS believes that Vermont must continue to make efforts to achieve an integrated and holistic health care system. However, working towards establishing a balance between mental health services provided in the hospital, and services delivered in the community, requires time to develop the necessary community supports to ensure all Vermonters have access to the care they need at the time they need it. We must ensure it is done a thoughtful way, driven by the needs of Vermonters, and not based on federal funding decisions. The future of IMDs, their role in our system of care, and their financial stability will become clear as we receive decisions about the phasedown plan and a potential waiver application.

[4] SMD # 18--011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance.