DISABILITY RIGHTS VERMONT

Senate Committee on Finance

H.96 An act relating to increasing the monetary thresholds for certificates of need

Disability Rights Vermont Testimony

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Disability Rights Vermont is the Protection and Advocacy agency for the State of Vermont. My name is Lindsey Owen, and I am the Executive Director at Disability Rights Vermont. I have been with the organization for over twelve years.

The Protection and Advocacy system was established after much attention in the media of horrific and negligent treatment of people with disabilities at a place operated by the State of New York that was supposed to be providing care to these individuals. The abuse and neglect was profound and shocking. As a result, P&As across the country receive a variety of federal grants to investigate and remedy abuse, neglect and serious rights violations impacting individuals with disabilities and perpetrated by state actors, facilities, caregivers, employers and others. Disability Rights Vermont is also designated by the Governor as Vermont's Mental Health Care Ombudsman.

During the course of its work and the exercise of its duties, DRVT regularly observes and hears stories related to individuals stuck and essentially warehoused in facilities when they could and should be receiving services in their community. H.96 will only exacerbate and expand these harms and these placements and allow the State of Vermont to continue to violate the Americans with Disabilities Act and the corresponding Integration mandate, only with greater ease.

It is indisputable that it is far more cost efficient and therapeutic to provide services to individuals at the earliest possible time and in their communities. At every level of increased restriction the costs, both monetarily and traumatically, associated with that level of care grow exponentially. DRVT has attempted to educate Vermont policy makers and the State departments, and yet facilities continue to appear without a corresponding investment in the community.

Attached to this testimony is a Disposition Delay obtained through a public records request regarding the placement of children and adolescents at the Brattleboro Retreat psychiatric facility. Please note the following statements:

- The Brattleboro Retreat (BR) provides essential capacity to Vermont's mental health system of care; it is the only inpatient psychiatric facility that serves

children and adolescents in Vermont. DVHA entered an Alternative Payment Model (APM) with the BR in March 2021. The BR receives a daily rate of $3,100 per bed for children and adolescents receiving inpatient psychiatric services at the BR regardless of the level of care (LOC) criteria that they are meeting (acute, sub-acute or awaiting placement). As long as the acute LOC criteria as defined by InterQual is met, continued inpatient hospitalization is expected. Page 1.

- In SFY24 there were 361 total authorized inpatient psychiatric admissions for children and adolescents under the age of 18 at the BR, for a total of 8,865 days. Of those 361 total admissions, 54 (15%) experienced disposition delays for a total of 3,459 days. Page 1.

That means, approximately one out of every 6-7 kids at the Retreat were there longer than they needed to be, if they needed to be there at all.

- Of the children experiencing discharge delays, broken down by State custodian:
  - For those delayed in DAIL custody, 79% of the time these kids spent at the Retreat was not medically necessary. Page 2.
  - For those delayed in DCF custody, 69% of the time these kids spent at the Retreat was not medically necessary. Page 2.
  - For those delayed in DMH custody, 73% of the time these kids spent at the Retreat was not medically necessary. Page 3.
- The number of disposition delay days more than doubled from SFY23 to SFY24. Page 3.
- The total amount of money spent for these days when these children did not meet acute level of care criteria was nearly $9,000,000.00. Page 4-5.

Currently, children are stuck for twice as long in the most restrictive settings than the prior year, and yet, instead of trying to create placements for those kids to discharge to, last year the State, the Department of Mental Health in particular, proposed a total of $23 million investment in creating more inpatient facility beds for children despite the $9 million waste in existing facilities.

This waste and investment in the most costly and restrictive healthcare facility settings occurred while there *is* a system of checks and balances in place. Increasing the monetary limits to let more proposals and construction fly under the radar and not less, and to explicitly exclude the institutional preference the State has demonstrated will not benefit any Vermonter, of any age or from any community. The impact would in fact funnel more and more resources toward a small fraction of Vermonters, who are forced into isolated settings that permit uses of force to be committed against them, who

probably don't need to be in those settings in the first place, if some alternative or earlier interventions in the community existed.

In the face of potential federal cuts to resources like Medicaid, a blanket free pass to the State of Vermont, who has historically ignored the mandate to serve people in the least restrictive settings, to construct whatever facilities they desire will have astronomically large costs to our State and to its most vulnerable residents, those with disabilities.

To the extent the committee votes on this bill, DRVT appreciates the acknowledgement of our work and our role and would gladly welcome additional conversation and is available to answer any questions.

Thank you,

Lindsey Owen

Children and Adolescents at the Brattleboro Retreat with Disposition Delays

The Brattleboro Retreat (BR) provides essential capacity to Vermont's mental health system of care; it is the only inpatient psychiatric facility that serves children and adolescents in Vermont. DVHA entered an Alternative Payment Model (APM) with the BR in March 2021. The BR receives a daily rate of $3,100 per bed for children and adolescents receiving inpatient psychiatric services at the BR regardless of the level of care (LOC) criteria that they are meeting (acute, sub-acute or awaiting placement). As long as the acute LOC criteria as defined by InterQual is met, continued inpatient hospitalization is expected. The goal is to discharge the member to a lower LOC to include residential placements, step down (e.g., Hospital Diversion), or to the community with or without outpatient supports as soon as the inpatient LOC becomes unnecessary. The BR is not responsible for disposition delays (as defined below) and receives the same daily rate as paid for members who are meeting medical necessity and acute level of care criteria. Disposition delays for the purpose of this memo are due to the following factors:

Child or adolescent

- is referred to the Case Committee Review (CRC) process to be cleared for residential LOC.
- is referred to and waiting for residential LOC (unable to return to the community in the interim).
- refuses to return home with the parent/guardian; or
- parent/guardian refuses to pick the member up upon discharge.

The DVHA has endeavored to explore whether continuing the APM and funding beds at the full rate continues to be appropriate and fiscally responsible. The data analysis is outlined below.

Data Analysis

Methodology- The Clinical Integrity Unit staff conducted a case-by-case analysis of the clinical documentation provided by the BR to assess the likely level of care determination regardless of disposition delays.

- Acute is authorized when a child or adolescent is exhibiting acute symptoms/behaviors and is receiving acute interventions.
- Sub-acute is authorized when the acute LOC is no longer necessary but requires a residential level of care and no discharge placement has been identified or discharge placement has been identified but not available.
- Waiting placement is authorized when the acute LOC is no longer necessary, and the child or adolescent is being discharged to a lower LOC (non-residential).

In SFY24 there were 361 total authorized inpatient psychiatric admissions for children and adolescents under the age of 18 at the BR, for a total of 8,865 days. Of those 361 total admissions, 54 (15%) experienced disposition delays for a total of 3,459 days.

Department of Aging and Independent Living (DAIL) was responsible for [redacted] of the children and adolescents experiencing disposition delays. [redacted] were either waiting for the CRC process to be completed or awaiting decisions/acceptance from residential facilities. [redacted] were related to parents' refusal to pick up members from BR at the set discharge date. The 5 DAIL placements spent 571 days in the hospital, 449 of those days were considered disposition delayed days. That is to say that 79% of the time spent in the hospital for these children and adolescents was not medically necessary.

For admissions where DAIL was lead, the number of delayed disposition days ranged from 23 to 171 days, with a median of 77 days. A breakdown of the number of disposition delay days is outlined below.

# disposition delay days	# children and adolescents
<31	[redacted]
31-60	[redacted]
61-90	[redacted]
91+	[redacted]

According to the analysis of the data, 10 inpatient days met the acute LOC criteria, 122 would have been at the sub-acute rate, and 317 would have been the awaiting placement. Therefore, a total of 439 days would not have been authorized at the acute rate. Using 439 as the denominator gives an average length of stay of 88 days for disposition delayed days not meeting acute criteria.

The Department of Children and Families (DCF) was responsible for 26 of the 54 children and adolescents experiencing disposition delays. Twenty-four were either waiting for the CRC process to be completed or awaiting acceptance from residential placements. [redacted] were waiting for a step-down placement. The 26 DCF placements spent 1,990 days in the hospital, 1,364 of those days were considered disposition delayed days. That is to say that 69% of the time spent in the hospital for these children and adolescents was not medically necessary.

For DCF children and adolescents, the number of delayed disposition days ranged from 2 to 169 days with a median of 42 days. A breakdown of the number of disposition delay days is outlined below.

# disposition delay days	# children and adolescents
<31	11
31-60	[redacted]
61-90	[redacted]
91+	[redacted]

According to the analysis of the data, 123 inpatient days met the acute LOC criteria 1,178 inpatient days would have been at the sub-acute rate, 63 inpatient days would have been awaiting placement rate. Therefore, a total of 1,241 days would not have been authorized at the acute rate. Using the 1,241 as a denominator gives an average length of stay of 48 days for delayed disposition days not meeting acute criteria.

The Department of Mental Health (DMH) was responsible for 23 of the children and adolescents experiencing disposition delays. Eleven were either waiting for the CRC process to be completed or awaiting decisions/acceptance from residential facilities. Eleven were related to parents' refusal to pick up members from BR at the set discharge date. There was one delay categorized as "other" and was out of the ability of DMH to resolve. The 23 DMH placements spent 2,253 days in the hospital, 1,646 of those days were considered disposition delayed days. That is to say that 73% of the time spent in the hospital for these children and adolescents was not medically necessary.

There was one admission that was shared between DAIL and DMH as the member became eligible for DAIL services during their stay. The days were distributed according to the DAIL eligibility date, yet the admission is being attributed to DAIL as they were the lead department for most of the disposition delay.

For admissions where DMH was lead, the number of delayed disposition days ranged from 6 to 285 days, with a median of 56 days. A breakdown of the number of disposition delay days is outlined below.

# disposition delay days	# children and adolescents
<31	[redacted]
31-60	[redacted]
61-90	[redacted]
91+	[redacted]

According to the analysis of the data, 150 inpatient days met the acute LOC criteria, 869 would have been at the sub-acute rate, and 627 would have been the awaiting placement. Therefore, a total of 1,496 days would not have been authorized at the acute rate. Using the 1,496 as the denominator gives an average length of stay of 63 days for disposition delayed days not meeting acute criteria.

Summary

In SFY24 out of 361 total authorized child and adolescent inpatient psychiatric admissions there were 54 admissions with disposition delays for a total of 3,459 days. For disposition delay days that would have not been authorized at the acute rate, the average length of disposition days for DAIL is 88, DCF is 48, and DMH is 62.

In comparison, for SFY23 out of 378 total authorized child and adolescent inpatient admissions, there were 48 admissions with disposition delays for a total of 1,477 days. The number of children and adolescents experiencing disposition days has slightly increased, by 6 members, but the corresponding number of disposition delay days is increasing significantly, doubling from SFY23 to SFY24. Despite having fewer admissions with disposition delays than DCF in SFY24, DMH has the highest percentage of disposition delay days.

Disposition Delay Days

	SFY23			SFY24		
Depart.	# of admits	# of disposition delay days	% of disposition delay days	# of admits	# of disposition delay days	% of disposition delay days
DAIL	[redacted]	179	12.12%	[redacted]	449	12.98%
DCF	20	562	38.05%	26	1,364	39.43%
DMH	27	736	49.83%	23	1,646	47.59%
Total	48	1,477	100.00%	54	3,457	100.00%

Under the APM, it is costing the state more than it would have under the old payment model especially due to the increased disposition delays.

- For DAIL:
  - At a rate of $3,100 per day, the 439 days that would not have met the acute LOC amounts to $1,360,900.00.
  - By comparison, if using the base rate payments for sub-acute and awaiting placement days, 122 days at the SA rate of $316.25 amounts to $38,582.50 and 317 days at the awaiting placement rate of $242.99 amounts to $77,027.83. Combined, the value of the days that would not meet the acute level of care equal $115,610.33.
  - This is a difference of $1,245,289.67.
- For DCF:
  - At a rate of $3,100 per day, the 1,241 days that would not have met the acute LOC amounts to $3,847,100.00.
  - By comparison, if using the base rate payments for sub-acute and awaiting placement days, 1,178 days at the SA rate of $316.25 amounts to $375,542.50 and 63 days at the awaiting placement rate of $242.99 amounts to $15,308.37. Combined, the value of the days that would not meet the acute level of care equal $387,850.87.
  - This is a difference of $3,459,249.13.
- For DMH:
  - At a rate of $3,100 per day, the 1,496 days that would not have met the acute LOC amounts to $4,637,600.00.
  - By comparison, if using the base rate payments for sub-acute and awaiting placement days, 869 days at the SA rate of $316.25 amounts to $274,821.25 and 627 days at the awaiting placement rate of $242.99 amounts to $152,354.73. Combined, the value of the days that would not meet the acute level of care equal $427,175.98.
  - This is a difference of $4,210,424.02.

- The impact of the BR APM combined with the significant increase of disposition delays results in an increased total cost of $8,914,962.82.

	BR APM		Base Rate Methodology					Impact
Department	Total disposition delay days not meeting Acute LOC	Acute rate $ 3100	# days SA	SA rate $316.25	# days AP	AP Rate $242.99	Total cost using base rate methodology	Difference
DAIL	439	$ 1,360,900.00	122	$ 38,582.50	317	$ 77,027.83	$ 115,610.33	$ 1,245,289.67
DCF	1,241	$ 3,847,100.00	1,178	$ 372,542.50	63	$ 15,308.37	$ 387,850.87	$ 3,459,249.13
DMH	1,496	$ 4,637,600.00	869	$ 274,821.25	627	$ 152,354.73	$ 427,175.98	$ 4,210,424.02
Total	3,176	$ 9,845,600.00	2,169	$ 685,946.25	1,007	$ 244,690.93	$ 930,637.18	$ 8,914,962.82