Updates for Act 173 Advisory Workgroup

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AHS Leadership Change

Since AHS Secretary, Al Gobeille left his position this summer Deputy Secretary, Martha Maksym has been Acting Commissioner and then earlier this fall DAIL Commissioner, Monica Hutt stepped in as Acting Deputy Secretary. Monday, October 28th, Mike Smith, became the AHS Secretary. Martha has returned to her position as Deputy Secretary and Monica is back at DAIL in her Commissioner position.

DMH Payment Reform

Beginning in August 2017, the Department of Mental Health, Department of Vermont Health Access, Vermont Care Partners, and Designated Agencies began a collaboration to design and implement payment reform for children and adult mental health services.

This culminated in a payment shift that began on January 1, 2019 which moved all Designated Agencies (community mental health agencies) out of fee-for-service payments into case rates.

WHY:

As a state we contract out a large percent of our mental health services to non-profit community partners (Designated Mental Health Agencies). We set their budgets, so they function in a capped system. We don't ask community partners what it costs to provide the services, instead we give them a set amount to meet the diverse needs of their clients. State funded mental health Programming is complex and currently resides across 6 Departments and 11 Divisions within the Agency of Human Services, and each silo operates independently. This lack of coordination has resulted in a system of care that can be fragmented, inefficient, and difficult to navigate. Payment structures often vary across programs, and can require complex, confusing and restrictive eligibility requirements and billing practices that limit providers' flexibility to deliver needed services.

Mental Health Payment Reform will begin to address these challenges and support the goal of promoting and improving the mental health of Vermonters by: Improving the **efficiency and coordination** of mental health programs and services around the State; simplifying payment structures to **increase flexibility and predictability of payments;** and shifting to Value-Based payment models that **reward outcomes and incentivize best practices**.

WHAT:

Mental Health Payment Reform supports a cultural shift in the way State funded mental health providers do business. We are moving the focus from counting how much we are doing to looking at how well we are doing. This shift is enabled by **giving communities more flexibility with funding and decision-making, so agencies can focus on the needs of the children, youth, adults and families they serve; and provide the right supports and services, at the right time.**

Payment for a large portion of existing state funded mental health services will be "bundled" into two core monthly case rates - Child and Adult. Providers will be paid a monthly case rate per client served based on a single service included in the bundled case rate until the agency's annual allocation is met. Payment reform is not about adding new money to the system; it is about reducing barriers and increasing flexibility to meet the needs of individuals and families. Payments will be "Value Based" meaning that they will be linked to quality and performance on a selected set of measures and will incentivize outcomes based on clinical best practice of care.

DMH 10-Year Strategic Planning

DMH has been engaging for months in a process that includes stakeholder engagement to do the following: Act 82, Section 3(c) (2017) amended by Act 200, Section 9 (2018): "The Secretary shall ensure that the evaluation process provides for input from persons who identify as psychiatric survivors, consumers, or peers; family members of such persons; providers of mental health services; and providers of services within the broader health care system."

This visioning process included 10 open forums over the summer to solicit feedback from Vermonters regarding our mental health system. The themes captured in these forums has been compiled and is now being utilized to create an action plan to take steps to *"consider implementation of current system changes resulting from healthcare reform, planned changes in inpatient capacity and other commitments of the Department of Mental Health, the Agency of Human Services, and the many partners, providers and payers who are responsible for the State's mental health system of care. The resulting vision will be used to create a framework for implementation strategies and a process to achieve a comprehensive continuum of integrated care."* Act 200 Legislative report

A final report to the legislature about the plan will be submitted in January to inform the next legislative session.

AHS Strategic Planning

AHS is also engaging in strategic planning that incorporates all of the departments within AHS.

- **Work to be accomplished**: Develop a 10-year agency-wide strategic plan (2020-2030) that can be presented to the Legislature as a draft November 1, 2019 and as final January 19, 2020.
- **Background**: Demographics and social/health trends are changing in Vermont. AHS is undergoing a service system analysis to understand how to proactively and responsively improve well-being into the future.
- **Stakeholders:** AHS frontline staff, division and department leadership, policy and planning, data, and financial experts are critical to this process. Additionally, clients, community partners, other state agencies, and legislators have essential perspective.

The Strategic Plan Framework will create conditions to:

- Respond to changing demographics and an analysis of social/health trends
- Respond to pressures and promising practices in the current AHS service delivery system

- Establish a unifying vision and identify critical practices to guide agency-wide reform over the next decade
- Develop a communication, engagement, and system governance plan for managing the strategic plan framework

Mobile Response

Mobile Response and Stabilization Services (MRSS) differ from traditional crisis services in that MRSS provides more upstream services. A mobile face-to-face response is provided to a **family-defined crisis** to provide support and intervention for a child/youth and their family, before emotional and behavioral difficulties escalate. MRSS has been shown in other states to be responsive to child, youth and family needs, clinically and cost effective in "averting unnecessary" higher levels of care in settings such as emergency departments, inpatient psychiatric care, residential treatment or other placement disruptions, and is often the first point of contact with families (NASMHPD 2018).

Other states instituted Mobile Response and Stabilization Services in response to a major tragedy such as a school shooting or pending legal action under EPSDT. **In Vermont, we would like to take a more proactive approach rather than waiting for a tragedy to drive system change. We know we are not immune to tragedy and we need to have the right resources in place to do all we can to reduce the likelihood of one happening in our state.**

Vermont strives to get upstream as a system, but due to many factors including funding levels, much of our system supports are available only in reaction to an identified problem. We want to shift from being reactive to responsive. When supports and stabilization are offered earlier for families in their chosen setting (home or community), we can shift the trajectory for children and their families, heading off the need for more intensive, expensive and/or longer-term services down the road.

To that end, a cross-agency group has been meeting for over a year to analyze data, participate in a multi-state peer-to-peer learning event and to determine how in Vermont we can have a different story that provides the services and supports families need to *avoid* a tragedy.

In Vermont we have the following challenges:

- ✓ Increase in children/youth (0-17) who go to Emergency Departments with a mental health crisis and then have to wait for days for a crisis plan to be put into place (inpatient, crisis alternative program, or community-based plan).
- ✓ Currently, Designated Agencies' emergency services are expected to provide "Mobile outreach capability and crisis stabilization services *as feasible within existing resources* to help prevent need for higher level of care" (emphasis added). There is a gap between the resourced capacity of the DA emergency services teams and the current demand for these services.

- ✓ The DA emergency services teams manage this gap between resource and demand by determining what constitutes a crisis and prioritizing crisis screening for inpatient admissions.
- ✓ Families and providers see a need for responsive, in-home community supports beyond screening.

Our goals to address these challenges include:

- Re-prioritize mobile response in our child and family system to respond to a *family-defined* crisis to help families in distress in a timely way through infusing resources to adequately meet the current demand.
- Interrupt a family-defined crisis and serve as a point of access for responding to the identified needs of the family so the child/youth can remain safe at home, in the community and school.
- MRSS is resourced for sustainability and effective response to local need.

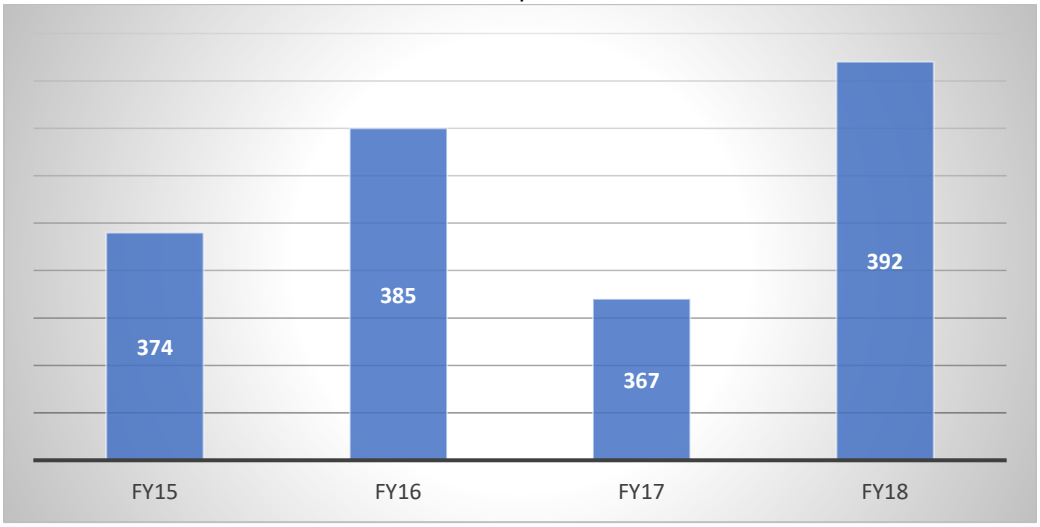
Continued Focus on the Number of Children and Youth in Residential Settings

- AHS is continuing to focus on how to have more children in community-based settings.
- As of 3rd quarter of FY19, there were 305 unduplicated children placed in residential settings by DAIL, DMH and DCF.
- Of these youth, there were 223 youth in state and 130 in out of state residential. This accounts for children/youth who moved and is therefore a duplicated count.

AHS Trends of Children/Youth Placed in Residential Settings

Includes all children placed through DMH, DAIL and DCF in Residential Settings.

These are unduplicated counts



Early Childhood and Mental Health

Building Bright Futures State Advisory Council identified early childhood and family mental health as a priority to explore in 2019. The Council heard from early childhood leaders working in the field, parents and policy makers. They explored data that demonstrated an increase in utilization of services at mental health designated agencies in Vermont and also learned the acuity of needs by Vermont families with young children has increased in recent years.

As the Council explored this topic, it is clear there are diverse strategies in use across the state providing supports in homes, early care and learning programs, community settings such as parent child settings, public and private mental health providers.

The language we use to talk about services for children and families is also varied. We say early childhood and family health, we talk about how to build resilience, social-emotional competence, and family stability. Having different language and frameworks may work in our respective settings but it makes it hard as a state to create a common vision. Reflecting on this image from Zero to Three, we agreed Vermont needs to create aligned language and visual as an important step to our ability to build a coordinated system that supports children and families' mental health.

This task force will

- create a vision statement with shared language and a visual continuum that will lead early childhood and mental health partners
- review different forms of positive mental health frameworks in use across Vermont
- policy recommendations to reach this shared vision

Policy recommendations will inform BBF's *How Are Vermont's young Children and Families? Report* and the *Act 264 System of Care Report*. The group will develop a white paper and present to the State Advisory Council in Fall 2019.

Success Beyond Six

Background from Act 72:

> (a) The Success Beyond Six program is based on agreements between the Designated Agencies and local schools, supervisory unions, or districts. The Agency of Human Services does not play a role in local funding decisions; however, the overall program spending is part of the Medicaid program and impacts overall Medicaid spending and the budget neutrality cap.
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> (b) Given the limited room in the Global Commitment Medicaid budget neutrality cap, the Agency of Human Services (AHS), the Agency of Education (AOE), and Department of Mental Health (DMH) shall assess and determine how to evaluate Success Beyond Six program spending against other competing priorities in the Medicaid program.
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> (c) AHS, AOE, and DMH shall report to the General Assembly on Success Beyond Six evaluation and oversight not later than January 15, 2020. The report shall include:
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> (1) an inventory of existing methods for providing school-based mental health services;

(2) analysis of the trend in school-based mental health programming that is funded through the Success Beyond Six program fiscal mechanism;

(3) evaluation of the program attributes;

(4) determination, in partnership with the Designated Agencies, of metrics for evaluating program outcomes; and

(5) a proposal for how AHS, AOE, and DMH should participate in Success Beyond Six spending decisions

The process to develop the report includes review of prior legislative reports on Success Beyond Six, review of national standards and bulletins on school mental health, review of Vermont data, and stakeholder input. The following stakeholders provided input:

1. Vermont Superintendents Association
2. Vermont Council of Special Education Administrators
3. Designated Agencies (DA): Child, Youth & Family Directors, School Mental Health Program Directors
4. Regional partnerships of DA and local educational agencies in Rutland, Chittenden, and Washington counties (PENDING)
5. Act 264 Board and the children's State Program Standing Committee
6. Medicaid and Exchange Advisory Board (PENDING)
7. Vermont Federation of Families for Children's Mental Health Board (PENDING)

Stakeholder input meeting agendas included overview of the intent of the report, review of the legislative questions, the context of why this matters, and questions seeking input from the stakeholder group to gain their perspective on each of the 5 report questions.

What we know so far?

Student (and family) needs have intensified and are often complex. Schools are identifying the need to address the mental and behavioral health needs of students and families.

Costs are rising, in small part due to legislative Medicaid rate increases, but primarily due to expanded local contracts and increasing number of FTEs. Numbers of students served through direct intervention – as open clients of the DA – have held steady, while more indirect supports are available through consultation, classroom supports, etc. Stakeholder feedback so far has indicated desire for more consultation and support for teachers; however, consultation and training are not Medicaid covered services. The flexibility of the case rate through direct intervention with identified students allows consultation to be available.

Success Beyond Six spending is higher for students with Autism Spectrum Disorder. SB6 spending is higher for more intensive interventions such as CERT and Behavioral Services.

We need to understand the implications of Act 173 on the partnership between local schools and DAs for school-mental health under Success Beyond Six Medicaid.