Budget Adjustment Act Testimony
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Group Therapy

Vermont Care Partners is concerned that the structure and rates for reimbursement of group therapy services as proposed by DVHA are not feasible and will result in the suspension of those services. Up until July 1, 2015, we received $60 per 90 minute session for each individual with DVHA Medicaid coverage. The new DVHA Medicaid rate was reduced July 1 to $40 per session (regardless of length) and was further reduced on January 1, 2016 to $15.80 per session provided by our Masters level clinicians. If this rate reduction goes forward in January we will be compelled to eliminate some of these services as we cannot sustain further losses than we already experience. Referrals to private clinicians will not be an answer, as they too, cannot accept this low level of reimbursement.

Due to our mission to serve Vermont's most vulnerable and at-risk population our outpatient program payer mix includes a high number of uninsured and underinsured people who are often served on a sliding fee scale which does not come close to covering the costs. In fact, each year the outpatient mental health programs in our system of care serve approximately 7000 people and sustain losses of $ 1 million. Our outpatient substance abuse programs have similar losses.

Group therapy is considered clinical best practice to meet the needs of specific populations, and the modality is typically more cost efficient than individual services. Some of the people we have been serving in group modalities may be switched to individual therapy, but at greater cost and with lower efficacy.

Diagnoses and treatment needs addressed in group therapy include: Substance abuse, trauma, PTSD, Borderline & OCD personality disorder, anxiety and depressive disorders, bi-polar disorders, pedophilia. We are serving people who have experienced domestic violence, incarceration and other traumatic life events.

Level of intensity ranges from 1.5 hour weekly group to 6 hours weekly (three 2-hour groups)

While we understand DVHA's mandate to ensure compliance with national coding standards and CMS regulations, it is equally important that these proposed changes do not eliminate access to an essential service. We urge you to encourage the Administration to set adequate rates and develop a resolution that maintains the financial feasibility of group therapy services.

Applied Behavioral Analysis

Overview

- Beginning in July 2015 DVHA secured a state plan amendment and established rates for ABA services that apply to private providers and DA/SSAs. These rates are significantly below specialized rehabilitation rates that DA/SSAs had been billing DMH for these services previously. Additionally, DVHA require several layers of prior approval and clinical review and limits which professional can bill to

higher level Board Certified Behavioral Analysts (BCBA0), instead of direct one-on-one behavioral technicians. Finally, there are limits on the hours that can be billed.

- Because of the cost of ABA services (intensity, in-home) and the cost of employing the highly skilled BCBA, the current rates dramatically impact both the private providers and DAs' ability to provide this service beyond a minimal capacity. The programmatic structure and cost of employing BCBAs make ABA services financially risky.
- Many of the DAs are restructuring their program to provide more group services and less in home supports and services. While this is counter to the best practice for ABA they are facing a decision between providing a small amount in an adjusted manner or not providing the service at all.
- If DA/SSAs could continue to be funded at the DMH Medicaid rates, we would continue to grow our Autism program to meet the growing demand.
- Given the new rates and structure, some of our well-trained workforce will leave the DA/SSA system and maybe even the state, because we will not be able to pay them adequately.
- Many of the DAs have waitlists and would be able to begin to take on those children if the rates supported the program structure and needs.
- All the DAs are gauging their ability to provide limited amount of ABA while not creating greater fiscal challenges for their agency.
- Several of the DAs have children they began to serve and will continue until the service is no longer necessary and they will not take on additional children.

History of ABA Services

- Act 158 was passed in 2012 to increase access to ABA services for children with a diagnosis of Autism Spectrum Disorder. The Act mandated that both private insurance and Medicaid fund ABA services.
- In legislative year 2013 a line item increase was added to DVHA's budget to pay for ABA services.
- At the time OPR did not have a recognized professional license for ABA providers even though they were certified, nor was there a state plan service for ABA. Therefore Medicaid could not pay private providers or DAs directly for this service. Funding was transferred to DMH to pay DAs through the DMH mechanism (using the state plan service of Specialized Rehabilitation) and DMH rates. Since there was no state plan service of ABA the service that best matched ABA was specialized rehabilitation services.
- During 2014 and 2015 DMH paid the DAs through their mechanism for ABA services while Medicaid explored a state plan amendment and worked with the legislature and OPR to establish an ABA recognized license so that Medicaid could pay private providers as well as DAs.

Designated Agency Vacancy Savings

Vermont Care Partners wants to clarify that designated agencies do not return funds to the State as vacancy savings when we have earned funds through the services provided. All agencies do have some level of vacancy savings that are used to cover expenses including recruitment and training costs. Vacancy savings are a sign of that our reimbursement rates are too low to recruit and retain qualified workers and can lead to loss of access to needed services.

In the case of the vacancy savings from the Howard Center in this line item of the Budget Adjustment Act, it is appropriate for the State to recoup these funds because the Howard Center was unable to fill positions to earn the revenue as anticipated. This program was part of the Act 79 work to improve community resources to reduce the demand for inpatient care.

Vermont Care Partners is strongly committed to payment reform and has been working with state government on a number of fronts to develop and pilot payment models that can improve service quality, outcomes and cost effectiveness. So far, the two IFS pilots have been very successful at meeting those goals. Vermont Care Partners wants to ensure that the payment model is honored and the goals of the pilot continue to be achieved.

The NCSS pilot has been in progress for just 18 months and the CSAC pilot has been in operation for 3 years. We need to let these pilots proceed as planned and agreed to and then properly evaluate the effectiveness of the funding and service delivery model, particularly as the Agency of Human Services is looking to expand the model across the system of care.

Vermont Care Partners does not support a rescission in FY 16 funding to NCSS for the IFS program which would enable AHS to recoup deferred funds from FY 14 which are supposed to be used for innovation and to cover future financial risk as documented in correspondence and specified in a signed agreement with the State. As we actively engage in payment reform in collaboration with State government our master grant and others agreements must be fully honored.

Further information has been provided to the Committee summarizing a legal opinion we received on this issue.