2006 Progress Report

of the

Mental Health Oversight Committee

January 16, 2007

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Part I. Statutory Authority and Responsibilities of the Mental Health Oversight Committee

The Mental Health Oversight Committee (MHOC) was created by the General Assembly in 2004 primarily to oversee the development and implementation of the Vermont Mental Health Futures Plan (Futures Plan) and to ensure that Vermonters have access to a comprehensive and integrated continuum of mental health services. (See Appendix #1 for statutory charge.) The MHOC also set out to identify the best clinical model for meeting the mental health needs of Vermonters.

The MHOC is a bipartisan committee comprised of senators and representatives who serve on the health and welfare, human services, appropriations, and institutions committees. The MHOC originally was set to cease to exist on July 1, 2006; however, the General Assembly extended its existence until July 1, 2009 and, in addition, added a requirement that the Committee provide annual progress reports to the relevant standing committees of the Legislature not later than January 15. (See Sec. 293a of No. 215 of the Acts of the 2005 Adj. Sess. (2006).) This is the first progress report of the Committee.

Part II. Summary of Committee Recommendations

Based upon its work in 2006, the MHOC makes the following recommendations, each of which is discussed in greater detail in Part IV of this report:

- Ensure a smooth and efficient transition to the 2007 Legislative Session
- Continue legislative monitoring of Futures Plan implementation
- Restore the Department of Mental Health and a Commissioner of Mental Health
- Establish enhanced leadership for the VSH recertification process
- Make improvements at the Vermont State Hospital
- Provide for legislative follow up on areas of further study needed to develop a comprehensive continuum of care for mental health services

Part III. Summary of 2006 Committee and Related Activities

The Committee met four times during the 2006 legislative session and five times during the 2006 interim and heard from a variety of individuals and organizations representing a broad spectrum of perspectives and interests. (See Appendix #4 for list of witnesses.) Topics addressed by the Committee included:

- Vermont Mental Health Futures Plan
- Futures Plan milestones, including phases of the certificate of need process
Current status of the Vermont State Hospital
Fletcher Allen Health Care’s perspective on the Futures Plan
Mental health governance
Hiring of a Deputy Commissioner of Mental Health
Department of Justice settlement agreement and follow-up site visit
Actuarial study and clinical leaders’ recommendation regarding psychiatric inpatient bed capacity

Note: Also during the 2006 interim, and outside the jurisdiction of the MHOC, an ad hoc informal work group was formed by the chairs of the committees on appropriations to focus on the funds needed for long-term implementation of the Futures Plan. In addition to the co-chairs of the MHOC and to Senator Snelling, members of this work group included Senators Kitchel and Bartlett and Representatives Heath, Larson, and Pugh, and also involved members of the Administration, including James B. Reardon, Commissioner of Finance and Management. In particular, with support of the Joint Fiscal Committee and Legislative Council, the work group considered the financial aspects of the Futures Plan to determine the viability of its full implementation. No conclusions were reached, although serious concerns were raised. Moreover, the workgroup met with staff of Vermont’s Congressional delegation to discuss the possibility of federal aid for the VSH and a follow-up memorandum was prepared for the delegation, requesting specific assistance. (See Appendix # 7.)

Part IV. Findings and Recommendations

1. Ensure a smooth and efficient transition to the 2007 Legislative Session

As the 2007 legislative session approaches, the MHOC is particularly concerned that the benefit of its work during the interim be communicated to the relevant legislative standing committees. The MHOC recognizes that, at this point, its responsibility for overseeing critical aspects of the state’s public mental health system should be transferred to the standing committees of jurisdiction, which are in a better position to devote the time and analysis needed relative to important policy decisions affecting the provision of mental health care to Vermonters. In addition, the committee’s expansive look at Vermont’s mental health system leads it to make the logistical recommendation that the House Committee on Human Services and the Senate Committee on Health and Welfare take the lead with respect to overseeing Futures Plan implementation and most other ancillary issues, and that the related work of other standing committees—such as Institutions, Appropriations, and Government Operations, for example (which will no doubt play a role in considering significant aspects of the Futures Plan)—inform and coordinate with the two, above-mentioned lead committees. In addition, and in order to assist with a seamless transition to the session, the chairs of the MHOC offer to provide a review of this progress report to the standing committees as these matters come up for consideration.
2. Continue legislative monitoring of Futures Plan implementation

As mentioned, a primary responsibility of the MHOC is to oversee development and implementation of the Futures Plan. Pursuant to the legislative directive in Secs. 141a and 141c of Act 122 (2004), the Futures Plan was prepared by the Secretary of Human Services, in consultation with the VSH future planning advisory group. (See Appendices #1 and #2 for statutory charges.) The purpose of the plan essentially is to provide a comprehensive implementation strategy for replacing the services currently provided by the VSH. The plan was approved by the MHOC on March 22, 2006 and by the Joint Fiscal Committee (JFC) on April 25, 2006.

The Futures Plan proposes a reconfiguration of the existing 54-bed inpatient capacity at the VSH into a new array of inpatient, rehabilitation, and residential services for adults, as well as new investments in community mental health services. The original plan proposed to create 32 new inpatient beds in three locations. The current plan proposes 50 new inpatient treatment beds. The increase in beds resulted from the findings of an actuarial study on bed capacity and from a clinical leaders’ recommendation. The increase was authorized implicitly by a plan amendment approved by the MHOC on September 19, 2006 and by the JFC on November 9, 2006, stating that:

The Vermont Mental Health Futures Plan (the Plan), as approved by the Mental Health Oversight Committee (MHOC) on March 22, 2006 and the Joint Fiscal Committee (JFC) on April 25, 2006, is amended as it relates to the proposed numbers for new inpatient beds and instead recognizes that the precise number of beds will be determined through the ongoing legislative and regulatory certificate of need process.

The 50 new inpatient beds will consist of both “intensive” and “specialized” care. The current preferred option is to create a single primary program with Fletcher Allen Health Care (FAHC), with additional specialized care programs at both Retreat Healthcare in Brattleboro and Rutland Regional Medical Center. The MHOC fully endorses partnering with general hospitals because such arrangements further the clinically recommended goal of integrating psychiatric care with general medical care.

Other components of the Futures Plan include: creation of two residential recovery and secure residential treatment programs; augmentation of the existing network of crisis beds for stabilization and diversion; development of a care management program; and additional resources for peer programming, supportive housing, and legal services.

The first residential recovery program, Second Spring, will be located in Williamstown. It will be an eleven to fourteen bed residential treatment program for adults suffering from severe and persistent mental illness, who are transitioning from acute inpatient care. More specifically, the program is designed to serve eleven individuals coming from the VSH, or any acute care facility or facilities that replace the VSH, who are ready and willing to move to a voluntary transitional recovery setting. It is a “step down” from acute patient care for individuals who have had long stays at the VSH and for whom
community-based discharge is not otherwise likely to occur. On November 1, 2006, a contract for personal services was entered into by the Department of Health and three community mental health centers: the Howard Center for Human Services, Inc.; Washington County Mental Health Services, Inc.; and, Clara Martin Center. It is anticipated that the facility will begin receiving patients in February 2007.

In addition, the Futures Plan includes several recommendations made to the General Assembly by then Secretary Charlie Smith on February 4, 2006. These include implementation of the Mental Health Plan for Corrections and other community based mental health services designed to strengthen the outpatient and co-occurring treatment infrastructure. For example, the recommendations include added capacity for adult outpatient services; outpatient services for offenders recently released from custody; expansion of the co-occurring disorders project; and public health prevention and education strategies.

The scope of the Futures Plan is broad, its intricacies numerous, and its potential costs high. It is estimated that the cost of the inpatient program, alone, if fully implemented, is estimated to result in a capital expense of $50 – $100 million. In light of these figures, it is imperative for the state to maximize the availability of federal dollars to help cover the cost of inpatient psychiatric care. To do that, Vermont must achieve the requisite level of clinical and financial integration with FAHC so as not to trigger the “IMD exclusion” in Medicaid and thereby forfeit federal Medicaid dollars. Treatment at a freestanding, somewhat independent psychiatric hospital having more than 16 beds would not be reimbursable under Medicaid. Avoiding the IMD exclusion will require significant logistical and legal analysis. (See Appendix # 6 for memorandum on IMD exclusion in Medicaid.)

The plan to replace the services currently provided by the VSH is currently undergoing regulatory scrutiny under Vermont’s certificate of need (CON) process. The application for a conceptual CON (phase I) was filed with the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA) on August 31, 2006 and, after a series of follow-up questions and answers, was ruled complete on November 13, 2006. Fourteen individuals and organizations have filed and been granted interested party status. A hearing will be held before the Public Oversight Commission (POC) on December 13, 2006 after which the POC will make a recommendation to the commissioner of BISHCA, who will make the final decision on whether to approve the Futures Plan. The commissioner’s decision is subject to appeal before the Vermont Supreme Court. If the conceptual CON is approved, the AHS may make expenditures for architectural services, engineering design services, and any other planning services needed in connection with the project. See 18 V.S.A. § 9434(e). Upon completion of the conceptual development phase of the project, the AHS will need to secure a final CON (phase II).

As a result of the conceptual CON requirements, the spending originally authorized in the by the General Assembly in the 2006 Capital Bill (see Appendix #3), for planning, design, and permitting associated with the Futures Plan has been delayed.
It is anticipated that a new primary inpatient program under the Futures Plan will not be in place until 2012.

Because of the significant financial and policy considerations associated with further development and implementation of the Futures Plan, the MHOC recommends that part of its oversight function be transferred to the relevant legislative standing committees during the upcoming 2007 session. The Committee believes that the standing committees, particularly the House Committee on Human Services and the Senate Committee on Health and Welfare, are in a better position to devote the time and analysis needed to help move the plan forward in a manner consistent with legislative intent and with the budgetary needs of the state.

3. Restore the Department of Mental Health and a Commissioner of Mental Health

The current configuration of the Vermont Agency of Human Services (AHS), placing the Division of Mental Health within the Department of Health, has impeded Vermont’s ability to improve the care and services provided within the State’s public mental health system. The Committee recommends, therefore, that a Department of Mental Health and a Commissioner of Mental Health be restored.

The current organizational structure is the result of a reorganization plan prepared by the AHS pursuant to a legislative directive issued initially in 2002 (Act 142, Sec. 118(m)), and then again in 2003 (Act 45). Under the AHS reorganization plan, the former Department of Developmental and Mental Health Services was eliminated, and the mental health services and oversight of the Vermont State Hospital were transferred to the new Division of Mental Health within the expanded Department of Health.

The Committee heard testimony indicating that the recent reorganization has had the unintended consequence of lessening resources, leadership, coordination, efficiency, and accountability for mental health services in Vermont. Moreover, the organizational change has led to the devaluation of the status of mental health within the overall public health system and has compromised the state’s commitment to providing optimal treatment and recovery services. In addition, there has been a lack of consistency of leadership over mental health programs and services. And, notably, there is a need for greater systemic, clinical, and organizational integration between substance abuse treatment and other mental health services to help facilitate the most efficient and effective provision of care for co-occurring disorders, in particular.

Upon learning of these concerns, the Committee concluded that restoration of a Department of Mental Health was necessary, especially in light of the existing crisis at the VSH. The Committee expressed these concerns and its recommendation in a letter to Secretary Cynthia LaWare, dated August 28, 2006. (See Appendix # 5.) In addition, the Committee formed a subcommittee to look at the issue more closely and work with the Administration. Members of the subcommittee included Senators Leddy and Snelling and Representatives Fisher and O’Donnell.
To date, the Administration has provided no response to the MHOC regarding its call for organizational change. This lack of dialogue has been of some disappointment to the MHOC, which continues to believe that restoration of a Department of Mental Health and a Commissioner of Mental Health are of paramount importance and integral to the success of the Futures Plan and Vermont’s overall public mental health system. The Committee recommends that, if the Administration remains unwilling to make changes, the General Assembly take legislative action to reinstate a Department of Mental Health and a Commissioner of Mental Health.

4. Establish enhanced leadership for the VSH recertification process

The decertification of the VSH by the Centers for Medicare and Medicaid Services (CMS) sent a strong signal to Vermonters about the need for immediate improvements in conditions at the state hospital. Also, as a result of decertification, the state is losing an estimated $9 million per year in federal dollars. For as long as the VSH continues to operate, it is imperative for the facility to be certified. If recertification is achieved, Vermont believes it may draw down federal Medicaid dollars for inpatient psychiatric care under the Global Commitment for Health Medicaid Section 1115 waiver, which expires in 2010.

Vermont’s relatively recent focus on community treatment, universally considered positive, resulted, unfortunately, in the unintended under-funding of the VSH. In 2002, then Commissioner Susan Besio, Department of Developmental and Mental Health Services, hired a consultant to respond to reports of severe problems, which resulted in a report entitled, “System Under Siege,” outlining significant, crisis-level problems. Ultimately, the hospital lost its Medicaid certification in 2003. (It had been lost previously in the 1980’s also.) The recent decertification history is as follows:

In March 2003, the CMS made the first of five site visits to VSH between March and September 2003. The first visit found major deficiencies in nursing coverage, the “Locked Door Policy,” and active treatment. The follow-up visit by CMS in June 2003 found VSH in compliance and approved the Plan of Correction implemented by VSH. In response to a patient suicide on August 8, 2003, and two complaints concerning care and services, CMS revisited the site on August 11 through 14, 2003, and August 20, 2003. As a result of these visits, CMS determined that “an immediate jeopardy situation was present in which patients’ health and safety on [Brooks 1] was at risk” and the hospital failed to “assure each patient received care in a safe setting,” failed “to assure patients received the necessary care and services” and used “inappropriate restraint techniques” (CMS Report Initial Comments dated 8/20/03). CMS gave VSH until September 17, 2003 to remedy the deficiencies or risk losing Medicaid provider status. On September 15, 2003, a second patient committed suicide. CMS terminated VSH as a Medicaid provider on September 30, 2003. The hospital regained certification briefly in November 2004, but was again decertified in early February 2005 following the unauthorized absences (“elopements”) of two patients while off campus.
Because of the lack of certification, the VSH is operating under a conditional license issued by the Vermont Board of Health.

The process of recertification is complex and labor-intensive. In addition, CMS has not been clear regarding the possibility of and requirements for recertification in the current facility. The MHOC recommends the creation of a “Recertification Leader” within the AHS to oversee and navigate the state through that process. Acting Commissioner Sharon Moffatt informed the MHOC at its meeting held on November 28, 2006 that the Agency of Human Services is in the process of filling such a position.

5. Make improvements at the Vermont State Hospital

Although the long-term plan is to close the VSH by the year 2012, it is without question essential for the state to make immediate improvements in the current conditions at the hospital. This will involve investments in renovations as well as in staff training and will require a thorough examination of the hospital’s clinical policies and standards to ensure they are designed to promote patient dignity and recovery.

The existing VSH facility has significant structural deficiencies. For example, the buildings are old and the rooms narrow, with poor heating and ventilation systems. All units are cramped, and there are no comfortable places for family visiting, program activities, or physical activity. The space for patients to meet with professional staff, for individual counseling, for instance, is also inadequate. There is little natural lighting in rooms or hallways, and the hallways are too narrow to allow for the transfer of restrained patients on regular beds; and bath and toilet facilities are not available in the rooms, but are in one location with multiple toilets and showers.

Repeated concerns have been raised regarding the use of restraints, seclusion, and emergency involuntary medications. Clinical improvements, however, have been difficult to monitor because of the lack of written standards and policies.

These shortcomings and numerous others have been documented in the CMS decertification process and also as part of the Department of Justice (DOJ) investigation, which began in 2004 shortly after decertification. Regarding the latter, Vermont and the DOJ entered into a Settlement Agreement, conditionally ending the federal litigation initiated by the DOJ based on alleged violations of patients’ rights. Still, the agreement requires the hospital to be subject to site visits every six months and to meet specific benchmarks over time, such as hiring additional staff.

Clearly, Vermont needs to make immediate improvements at the VSH for the safety and well-being of the current staff and patient population. Accordingly, the MHOC recommends that the Administration makes needed improvements known to the General Assembly, which, in turn, should address them by making the necessary appropriations. With respect to some of the structural deficiencies, the Committee recommends that the Committees on Institutions take the lead in addressing these matters in the Capital Bill.
6. Provide for legislative follow up on areas of further study needed to develop a comprehensive continuum of care for mental health services

There are a number of specific subjects either mentioned in the Committee’s other recommendations or referenced in its discussions that remain in need of further attention. For the benefit and awareness of the committees of jurisdiction, the MHOC would like to mention them here.

A. Regarding the Futures Plan and the system of care:

   i. Integration of the Corrections Mental Health Plan and offender outpatient service components of the Futures Plan and coordination with the work of the Corrections Oversight Committee, including the assessment of needs for inpatient care and sub-acute levels of care for the incarcerated population.

   ii. Planning within the inpatient/residential components for the different categories of VSH patients under criminal court jurisdiction ("forensic patients") who do not qualify as needing an inpatient level of care; are not sufficiently "stable" or with a risk level appropriate to the secure residential model; and cannot be housed in correctional facilities based upon their legal status (not guilty by reason of insanity; not competent to stand trial; or under observation for competency evaluation).

   iii. Integration of mental health and substance abuse services to clients throughout the delivery system.

   iv. Policy and fiscal implications of models that transfer some or all aspects of services (capital acquisitions, programs) to entities outside the designated agency system, and in particular, to for-profit entities, such as the Bradford substance abuse program and the property purchased for the Second Spring community recovery program in Williamstown.

   v. Integration of the Futures Plan with the chronic care initiative.

   vi. Administration responses to evolving Futures Advisory Committee recommendations for essential Futures Plan components.

   vii. Application of the priorities and recommendations from the Futures Committee, in accordance with its original legislative charge.

   viii. Status of revisions to the timeline of plan components for FY’07 with fiscal implications for budget adjustment, including possible reallocations such as housing contingency funding that can be implemented immediately to address the VSH census. (See VSH issues list below.)
ix. Evaluation of the designated hospitals' role in the Futures plan and the capacity and sustainability of inpatient psychiatric care in the state and review of the process and outcome of the CMS investigation of the Rutland inpatient program.

x. Ongoing communication with VSH employees.

B. Regarding the Futures Plan Certificate of Need process:

i. Strategic planning steps for evaluating inpatient options, assuming a conceptual certificate of need is granted.

ii. Response to concerns raised by interested parties, and how they will be addressed during the conceptual development phase, including in particular: follow up to the unaddressed FY’07 capital budget directive concerning staff at VSH; the process and criteria for identifying appropriate prospective "satellite” locations; and concerns of municipalities in Chittenden County.

iii. Integration of the fiscal planning for the community system of care in relationship to the planning and development for an inpatient CON application.

C. Regarding the Vermont State Hospital:

i. Safety of the current environment given the sustained high census at close to maximum capacity.

ii. Potential impact of continued census pressures on closing beds at the VSH as community recovery residential beds open; the status of the strategy for closing VSH beds at that time; and the fiscal impact if beds are not closed.

iii. Analysis of the causes of increased census pressures over the past nine months, and of multi-year trends of comparative rates of growth of involuntary and voluntary hospitalization relative to population growth and system capacity.

iv. Status and functioning of the public accountability component under the new VSH governing body bylaws developed after VSH decertification.

v. Status of a strategic plan to attain recertification.

vi. Status of a strategic plan, and transparency and accountability for that plan, to reduce the use of restraint and seclusion at the VSH.
Appendix #1. Creation of the Mental Health Oversight Committee

Act No. 122 (2004)

Sec. 141c. THE MENTAL HEALTH OVERSIGHT COMMITTEE

(a) The mental health oversight committee is created to oversee the development and implementation of the secretary of human services’ strategic plan to develop alternatives for services currently provided by the Vermont state hospital and to ensure that consumers have access to a comprehensive and adequate continuum of care and Vermont has a financially sustainable department of developmental and mental health services designated agency provider system. The committee shall be composed of one member from each of the house committees on health and welfare, institutions, and appropriations and a member-at-large to be appointed by the speaker of the house, not all from the same party, and one member from each of the senate committees on health and welfare, institutions, and appropriations and one member-at-large to be appointed by the committee on committees, not all from the same party. Initial appointments shall be made upon passage.

(b) The committee shall review whether the secretary’s study on the department of developmental and mental health services designated agency provider system required in Sec. 141 of this act, the strategic plan for developing alternatives to the Vermont state hospital required in Sec. 141a of this act, and the department of corrections mental health services plan achieve the goals and principles stated herein effectively, efficiently, and satisfactorily, including that the findings and recommendations of the reports are coordinated and complementary. The committee shall specifically:

1. solicit input from individuals and their families served by the mental health system;
2. monitor the study and planning processes and time lines;
3. measure the efforts of the agency of human services against the goals and principles described in this act; and
4. review and approve, modify, or disapprove the recommendations contained in the reports required by Secs. 141 and 141a of this act and authorize preliminary implementation steps for developing alternatives to the services currently provided by the Vermont state hospital developed within the context of long-range planning for a comprehensive continuum of care for mental health services.

(c) Based on the reports required by Secs. 141, 141a, and 141b of this act, the committee shall recommend areas of further study needed to develop a comprehensive continuum of care for mental health services.

(d) The committee is authorized to meet up to six times per year while the general assembly is not in session to perform its functions under this section.

(e) The secretary of the agency of human services shall report to the committee as required by the committee and Secs. 141 and 141a of this act and this section.

(f) Members of the committee shall be entitled to compensation and reimbursement for expenses under section 406 of Title 2.

(g) The secretary of administration, the legislative council, and the joint fiscal office shall provide staff support requested by the committee.

(h) The committee shall cease to exist on July 1, 2006.
Appendix #2. Creation of the Futures Advisory Group

Act No. 122 (2004)

Sec. 141a. VERMONT STATE HOSPITAL FUTURE PLANNING ADVISORY GROUP

(a) It is the intent of the general assembly that all mental health programs, services, and supports, including inpatient psychiatric services, be provided to individuals with psychiatric disabilities or diagnoses or emotional disorders in a holistic, comprehensive continuum of care, that consumers be treated at all times with dignity and respect, that public resources be allocated efficiently and produce the best positive outcomes, and that direct services overseen and provided by the agency of human services and its community partners be client- and family-centered and -driven, accessible, and culturally competent.

(b) The secretary of human services shall be responsible for the development and, upon approval by the mental health oversight committee and joint fiscal committee, implementation of a comprehensive strategic plan for the delivery of services currently provided by the Vermont state hospital developed within the context of long-range planning for a comprehensive continuum of care for mental health services. The secretary shall upon passage establish a statewide state hospital future planning advisory group to advise the secretary on development and implementation of a strategic plan related to developing alternatives to the services currently provided by the Vermont state hospital.

(c) The members of the state hospital future planning advisory group may consist of the members of the current Vermont state hospital advisory committee. If the members of the Vermont state hospital advisory committee are unwilling or unable to serve as the members of the state hospital future planning advisory group for some or all of the functions identified in this section, a specific group shall be created with members appointed by the secretary. In either instance, the state hospital future planning advisory group shall have members representing the following: designated community mental health agencies; designated hospitals; the adult program standing committee; consumers and their family members; psychiatric and nursing staff of the Vermont state hospital; a recent patient of the Vermont state hospital; patient rights protection organizations; Vermont legal aid; the department of corrections; developmental services; child and adolescent mental health services; the Vermont psychiatric association; the Vermont psychological association; and the Vermont state employees’ association.

(d) Members of the state hospital future planning advisory group not receiving compensation for service on the advisory group from another source are entitled to compensation under section 1010 of Title 32.

(e) The secretary or designee shall consult with the advisory group on all aspects of strategic planning, including methods of seeking further public input, investigation of program options and policies, and recommendations concerning organization, operations, funding, and implementation.

(f) The principles guiding the state hospital future planning advisory group in creating the immediate and long-term plans for the Vermont state hospital shall include the following:
(1) an understanding of the role of active treatment within the goal of recovery;
(2) an understanding of the role of trauma in the lives of individuals;
(3) accessible general medical care;
(4) minimal use of involuntary interventions such as seclusion, restraint, and involuntary medication;
(5) staff training in the use of safe and appropriate alternatives to involuntary interventions;
(6) consumers’ participation in the development and implementation of their treatment plans;
(7) consumers’ right to privacy and the right to have information regarding their care remain confidential, unless disclosure is authorized by the consumer or required under the law;
(8) ongoing consumer and community input with regard to program oversight and development; and
(9) accountability for all components of the mental health care system.

(g) The state hospital future planning advisory group shall consider and make recommendations to the secretary on the following:

1. in general, the future of Vermont’s inpatient psychiatric programs, including those currently provided by the Vermont state hospital and, more specifically, whether new general or forensic inpatient programs should be created, either in partnership with designated hospitals or with hospitals or other facilities that do not currently provide inpatient psychiatric services;
2. designs for programs that are responsive to changes over time in levels and types of need, service delivery practices, and sources of funding;
3. whether designated hospitals should be encouraged to expand existing psychiatric services;
4. whether additional community-based, hospital alternative, or diversion programs should be developed;
5. whether the state should expand community-based peer run programs;
6. whether to create a flexible individual case management program to fund support services necessary to keep individuals out of the hospital;
7. how to design mental health services to maximize safety and ensure appropriate protection for the legal rights of consumers;
8. the development of ongoing quality monitoring and consumer satisfaction programs;
9. methods for maximizing federal funding sources and mental health coverage under private and public insurance plans;
10. the necessity of developing housing alternatives, including group homes, supportive housing, and independent living options;
11. the integration of primary care with the mental health system of care, including the need for education on the appropriate uses of psychotropic medications and follow-up care;
12. governance issues, including governance of the Vermont state hospital and an assessment of the role of the board of mental health and whether new members should be appointed; and
(13) ways to improve judicial proceedings concerning involuntary treatment and involuntary medication.

(h) On or before October 15, 2004, the secretary shall prepare and present for approval to the mental health oversight committee an outline of the findings and recommendations for replacement of the functions of the Vermont state hospital.

(i) On or before January 15, 2005, the secretary shall prepare and present to the mental health oversight committee and the joint fiscal committee a report containing a comprehensive implementation plan for replacing the services currently provided by the Vermont state hospital developed within the context of long-range planning for a comprehensive continuum of care for mental health services. The report shall include proposals for legislation and capital and operational funding needed to implement the plan.

(j) For purposes of this section, the state hospital future planning advisory group shall cease to exist on July 1, 2006.
Appendix #3. Legislative Oversight of Futures Plan Implementation

Act No. 147 (2006)

Sec. 4. HUMAN SERVICES

(a)(1) The sum of $1,000,000 shall be expended by the department of buildings and general services for the agency of human services for continued planning, design, and permitting associated with the creation of a new inpatient facility to replace the current Vermont state hospital, which shall be from general funds appropriated in No. 215 of the Acts of the 2005 Adj. Sess. (2006) (the Fiscal Year 2007 Appropriations Act).

(2) No portion of this appropriation shall be encumbered or disbursed:

(A) Unless used solely for costs incurred in connection with work required by the Vermont State Hospital Futures Plan (“the Plan”) required by Sec. 141a of No. 122 of the Acts of the 2003 Adj. Sess. (2004), as approved by the joint mental health oversight committee (“JMHOCS”) on March 22, 2006 and by the joint fiscal committee (“JFC”) on April 25, 2006, which shall include:

(i) Work necessary to complete an application for a conceptual certificate of need under subchapter 5 of chapter 221 of 18 V.S.A.; and

(ii) Work authorized by a conceptual certificate of need necessary to complete an application for a certificate of need under subchapter 5 of chapter 221 of 18 V.S.A.; and

(B) Until a detailed itemization of the specific manner in which the funds shall be spent is presented to and approved by the JMHOCS and the JFC.

(3) The department of buildings and general services and the agency of human services shall report at each remaining meeting of the JMHOCS and of the JFC during calendar year 2006 and to the house committee on human services, the senate committee on health and welfare, and the house and senate committees on appropriations and on institutions (collectively the “Committees of Jurisdiction”) in January 2007 regarding:

(A) The progress made on the planning, design, siting, and permitting of the new state hospital facility, including specific updates on steps being taken consistent with subchapter 5 of chapter 221 of 18 V.S.A regarding the certificate of need process.

(B) The status of negotiations, if any, with a nonstate partner regarding the resolution of outstanding issues, including building ownership, staffing, and administrative responsibilities. “Staffing” shall include demonstrated due diligence in support of the statement in the Vermont futures strategic implementation plan of July 11, 2005 that the “expertise and experience of the current VSH staff is a valuable resource” by identifying potential avenues that would enable current qualified staff to maintain their status and contractual benefits as Vermont state employees.
Appendix #4. Mental Health Oversight Committee 2006 Witness List

Dr. Robert Pierattini, Chair, Department of Psychiatry, Physician Leader at Fletcher Allen Health Care
Paul Jarris, Commissioner, Vermont Department of Health
Paul Blake, Deputy Commissioner, Division of Mental Health, Vermont Department of Health
Beth Tanzman, Director of Futures, Division of Mental Health, Vermont Department of Health
Conor Casey, Vermont State Employees’ Association
Goldie Watson, Nursing Supervisor
Tasha Wallis, Commissioner, Department of Buildings and General Services
Mike Kuhn, Architect, Department of Buildings and General Services
David Burley, Director of Engineering, Department of Buildings and General Services
Representative John Rogers
Cynthia LaWare, Secretary, Vermont Agency of Human Services
Stuart Graves, MD, Medical Director, Washington County Human Services & Northeast Kingdom Human Services
Paul Dupre, Executive Director, Washington County Mental Health
Theresa Alberghini DiPalma, Senior VP of Government and External Relations, Fletcher Allen Health Care
Ken Libertoff, Vermont Association for Mental Health
Laura Ziegler, Concerned Citizen
Ed Paquin, Vermont Protection and Advocacy
Wendy Beinner, Chief Counsel, Mental Health Division, Vermont Department of Health
Ira Sollace, CFO, Agency of Human Services
Bruce Spector, Chief Legal Counsel, BISHCA
Christine Oliver, Deputy Commissioner, BISHCA
Dr. Martha Lang, Concerned Citizen, Burlington
Larry Lewack, Executive Director, NAMI-Vermont
Barbara Cimaglio, Acting Deputy Director, Division of Mental Health, Vermont Department of Health
Meg O'Donnell, Assistant General Counsel, Fletcher Allen Health Care
Gail Rushford, Personnel Administrator, Agency of Human Services
Xenia Williams, Member, Vermont State Hospital Futures Advisory Committee
Joe Hagan, MD, Burlington Pediatrician
Judy Shaw, RN, MPH, Executive Director, VT Child Health Improvement Program, UVM College of Medicine
Marlene Maron, PhD, Director of Psychological Services, Fletcher Allen Health Care
Julie Tessler, Vermont Council of Developmental and Mental Health Services
Judith Hayward, Executive Director, Health Care and Rehabilitative Services of Southeastern Vermont
Appendix #5. MHOE Letter Regarding Department of Mental Health

August 28, 2006

Secretary Cynthia D. LaWare
Agency of Human Services
103 South Main Street
Waterbury, Vermont 05671-0201

Dear Secretary LaWare:

We are writing to express a growing concern regarding the placement of the Division of Mental Health within the Department of Health. We realize you are aware of this issue and greatly appreciate your evident openness to engaging with us in a comprehensive and sensitive reassessment of your agency’s organizational structure. Among the members of the Mental Health Oversight Committee, there is unanimity that a change is warranted.

In short, it is our view that the complexity, breadth, and critical nature of the policy choices currently facing the division underscore the need for strong leadership, complete focus, clear accountability, adequate resources, and stability now and in the future. These features, we believe, will be reinforced by restoring a Department of Mental Health and a Commissioner of Mental Health.

We understand the decision to establish a Division of Mental Health within the agency’s recent reorganization was well-intentioned. Nonetheless, it has become clear that our public mental health system is suffering because of that decision, and we need to act quickly to reassert our commitment to providing high quality mental health services to the people of Vermont.

Indeed, time is of the essence. We acknowledge the enormous pressures on your agency at this time, and we fully support the need for an expedited process to reach agreement on the leadership structure for mental health services in Vermont.

Thank you for your thoughtful attention to this matter.

Sincerely,

/s/ Sen. James Leddy, Co-Chair
/s/ Sen. Philip Scott
/s/ Sen. Diane Snelling
/s/ Sen. Jeanette White

/s/ Rep. Michael Fisher, Co-Chair
/s/ Rep. Anne Donahue
/s/ Rep. Gail Fallar
/s/ Rep. Pat O’Donnell
Appendix #6. IMD Memorandum

Vermont Legislative Council

115 State Street • Montpelier, VT 05633-5301 • (802) 828-2231 • Fax: (802) 828-2424

MEMORANDUM

To: Interested Parties

From: Maria Royle, Legislative Counsel

Date: September 5, 2006

Subject: The Vermont Futures Plan and the Medicaid IMD Exclusion

With the impending closure of the Vermont State Hospital (VSH), there is a need to clarify several issues related to Medicaid coverage for beneficiaries living in institutions for mental diseases (IMDs), especially with respect to the claiming of federal financial participation (FFP) for services provided to those beneficiaries. The availability of federal money for providing services and treatment to individuals with mental illness will have a significant impact on the cost of the Futures Plan.

This memorandum addresses the following: the prohibition in federal law from claiming FFP for beneficiaries in IMDs (the IMD exclusion); the definition of an IMD; criteria for determining when the IMD exclusion applies to psychiatric units that are a part of larger institutions, such as general acute care hospitals; exceptions to the IMD exclusion; and, judicial application of the IMD exclusion in specific instances.

The purpose of this memorandum is to provide guidance to the State’s provision of inpatient psychiatric care so that the IMD exclusion is not triggered under implementation of the Futures Plan and thus the availability of federal Medicaid dollars is maximized.

What is the IMD Exclusion?

Since the time the Medicaid program was enacted in 1965, institutions providing long-term care for mentally ill patients have been specifically excluded from participating in Medicaid. The Medicaid Act, therefore, excludes from the definition of “medical assistance,” for which FFP is available under Medicaid, items or services provided to patients between the ages of 21 and 64 in any IMD.¹ The basis for the exclusion is not evident in the Act itself; however, courts have considered its legislative history. At least one court has noted that the underlying policy can be traced to a 1963 House of Representatives’ report finding that state mental institutions were simply warehouses and

¹ 42 U.S.C. § 1396d(a); Title XIX (Medicaid) of the Social Security Act (SSA), §1905(a), paragraph (B); 42 C.F.R. § 435.1008 (Medicaid FFP for institutionalized individuals).
furnished no treatment and thus were inappropriate facilities for Medicaid coverage purposes.\(^2\) The United States Supreme Court, in analyzing the IMD exclusion, also referenced the Committee Reports on the Medicaid Act, and indicated the underlying policy for the exclusion stems from the view that long-term care in mental institutions has traditionally been the responsibility of the States and, in addition, there is at least an implicit preference for providing alternative forms of care for mental illness at the community level.\(^3\) (A preference, incidentally, Congress codified in 1988 with enactment of the 16-bed or less exemption.\(^4\))

**What is an IMD?**

An “institution for mental diseases” is defined under Title XIX (Medicaid) of the Social Security Act (SSA) as “a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services.”\(^5\) That definition is elaborated upon in federal regulations, which add that, “whether an institution is an institution for mental diseases is determined by its **overall character** as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.”\(^6\) The regulations define an “institution” as “an establishment that furnishes (in single or multiple facilities) food, shelter, and some other treatment or services to four or more persons unrelated to the proprietor.”\(^7\)

The State Medicaid Manual (SMM) also includes federal guidelines for determining whether an institution is an IMD. Specifically, the guidelines provide five criteria to be considered in determining whether a facility’s **overall character** is that of a facility established or maintained primarily for the care and treatment of individuals with mental diseases. Those criteria are as follows:

1. The facility is licensed as a psychiatric facility;
2. The facility is accredited as a psychiatric facility;
3. The facility is under the jurisdiction of the State’s mental health authority; (This criterion does not apply to facilities under mental health authority that are not providing services to mentally ill persons.)
4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients’ records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients is receiving psychopharmacological drugs; and

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\(^2\) *Minnesota v. Heckler*, 718 F.2d 852, 863-64 (8th Cir. 1983) (citing view that state mental institutions were custodial rather than therapeutic in nature).


\(^4\) 42 U.S.C. § 1396d(i).

\(^5\) 42 U.S.C. § 1396d(i); Title XIX (Medicaid) of the SSA, § 1905(i).

\(^6\) 42 C.F.R. § 435.1009.

\(^7\) 42 C.F.R. § 435.1009 (for purposes of Medicaid FFP, definitions relating to institutional status).
5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases.  

**Applying IMD Analysis to Facilities Having Multiple Components**

In some instances, for example where there are multiple components of one facility, it may not be clear to which entity the IMD criteria apply. This issue may arise with respect to a psychiatric unit of a general acute care hospital. Whether to apply the criteria to the psychiatric unit or to the larger, general hospital depends on the relationship between the two. The SMM provides guidelines on which entity is to be assessed. The guidelines specify that whether components are independent, and therefore analyzed separately, is determined with reference to the following inquiries:

1. Are all components controlled by one owner or one governing body?
2. Is one chief medical officer responsible for the medical staff activities in all components?
3. Does one chief executive officer control all administrative activities in all components?
4. Are any of the components separately licensed?
5. Are the components so organizationally and geographically separate that it is not feasible to operate as a single entity?
6. If two or more of the components are participating under the same provider category (such as nursing facilities), can each component meet the conditions of participation independently?

If it is determined that a component is independent, the IMD criteria are applied to that component unless it has fewer than 17 beds.

The guidelines also make clear that components that are certified as different types of providers are considered independent from each other. (However, certification as a single entity, alone, will not ensure a psychiatric unit of a general hospital will not be analyzed separately.) Federal law imposes certain restrictions on the certification process for purposes of Medicaid and Medicare reimbursement. Whether two or more facilities may be certified as a single hospital—for example, if two hospitals merge or if one hospital opens an additional, geographically separate facility—is addressed in the federal regulations on Medicare cost reimbursement as well as in the federal guidelines for Medicare hospital certification found in the State Operations Manual (SOM).

The SOM guidelines on hospital certification state that merged hospitals or distinct units that want to be designated part of a single hospital must meet the criteria for

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8 State Medicaid Manual (SMM), § 4390, subsection C. 
9 SMM § 4390, subsection B. 
10 See New York v. Shalala, discussed infra. 
11 42 C.F.R. § 413.65; SOM §§ 2004 and 2024. 
12 42 C.F.R. § 482.1(a)(5).
provider-based status.\(^\text{13}\) Those criteria are defined in federal regulations.\(^\text{14}\) Provider-based status is limited to subordinate facilities that are an integral part of a “main provider,” and may not be applied to freestanding, independent entities. A “main provider,” may function as a single entity while owning and operating multiple provider-based departments, locations, and facilities that are treated as part of the main provider for Medicare purposes.

The regulations define a “provider-based entity” as a “provider of health care services . . . that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the ownership and administrative and financial control of the main provider.”\(^\text{15}\) Any facility or organization for which provider-based status is sought, whether located on or off the campus of a potential main provider, must meet all of the following requirements, as determined by CMS:

1. Licensure. The main provider and the subordinate facility must operate under the same license, unless state law requires otherwise.
2. Clinical services. The clinical services of the main provider and the subordinate facility must be integrated with respect to professional staff privileges, oversight and monitoring, medical director accountability, medical staff committee responsibility, integrated medical records, and integration of inpatient and outpatient services.
3. Financial integration. Full integration as evidenced, for example, by shared income and expenses.
4. Public awareness. The facility seeking provider-based status is held out to the public and other payers as part of the main provider.
5. Hospital-based entities must meet all the obligations defined in regulation that related to billing, provider agreements, nondiscrimination provisions, etc.

There are additional federal requirements applicable to off-campus facilities—relating to: ownership and control; administration and supervision; location (within a 35-mile radius of the main provider)—as well as to off-campus facilities operating under management contracts.

**Exceptions to the IMD Exclusion**

FFP is available for services provided to patients in IMDs who:
- Are 65 years of age or older\(^\text{16}\)
- Are admitted to a facility with less than 17 beds\(^\text{17}\)
- Are under age 65 and on conditional release or convalescent leave from an IMD\(^\text{18}\)

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\(^{13}\) SOM §2024.

\(^{14}\) 42 C.F.R. § 413.65.

\(^{15}\) 42 C.F.R. § 413.65(a)(2).

\(^{16}\) 42 U.S.C. § 1396d(a)(14).

\(^{17}\) 42 U.S.C. § 1396d(i).

\(^{18}\) 45 C.F.R. § 435.1008(c).
• Are under age 21 and receiving psychiatric inpatient care in an accredited facility\textsuperscript{19}
• Were receiving psychiatric inpatient care in an accredited facility prior to their 21\textsuperscript{st} birthday; remain in the facility on their 21\textsuperscript{st} birthday, and continue to require inpatient services until the end of their continuous stay or until their 22\textsuperscript{nd} birthday, whichever occurs first\textsuperscript{20}

**Judicial Application of the IMD Exclusion to Multiple Components**

There have been numerous cases concerning the IMD exclusion, generally, but this memorandum will address two cases dealing specifically with the application of the IMD criteria to facilities that are a distinct part of larger institutions which are not primarily for the care and treatment of persons with mental diseases.

In *New York v. Shalala*,\textsuperscript{21} the federal district court held that the IMD exclusion applied to inpatient psychiatric care provided at two Westchester branches of New York City hospitals, and, therefore, reimbursement for that care was not available under the Medicaid program. The court determined that, even though the New York and Westchester facilities met the certification standard for merged facilities, the fact that they had separate licenses, accreditations, and provider numbers, and that they charged different per diem rates and submitted separate cost reports rendered the facilities so organizationally and geographically separate as to make it impossible for them to operate as a component of a single hospital.

In *California Department of Health Services*, DAB No. 1595 (1994), the Health and Human Services Departmental Appeals Board (DAB) held the IMD exclusion applied to services provided at East Valley Pavilion (EVP), a 99-bed facility that was certified to provide first, skilled nursing facility (SNF) services and later, nursing facility (NF) services. First, the court held that, although EVP was not licensed as a psychiatric hospital, its overall character was such that it met the statutory and regulatory definitions of an IMD. Second, the court held that the IMD exclusion applied to EVP even though it was a distinct part of a general acute care hospital located nine miles away. In reaching the latter determination, the court noted that the relationship between the entities stemmed from the fact that they were county owned and operated under a consolidated license, but EVP was operated on a day-to-day basis by the County Health Department, not the hospital. Although the hospital provided certain ancillary and support services, the Department was responsible for providing all care required by patients in EVP, and for hiring and supervising the nursing staff, therapists, and other personnel. In addition, patients were admitted under EVP’s separate admission policies, not the hospital’s, and the services provided by EVP were billed for by the Department, not the hospital. Finally, the hospital did not furnish food or shelter to individuals admitted to live in EVP. The court explained that permitting the county to evade the IMD exclusion in this instance would only invite other public agencies to structure how they provide services in

\textsuperscript{19} 42 U.S.C. § 1396d(a)(16).
\textsuperscript{20} 42 U.S.C. § 1396d(h).
\textsuperscript{21} 1997 WL 610771 (S.D.NY.), No. 95 Civ. 10258 JSM.
a way that would render the IMD exclusion meaningless and contravene congressional intent.

Conclusion
By carefully considering the legislative intent behind the IMD exclusion in Medicaid, as well as the relevant federal regulations, guidelines, and case law, Vermont can plan to provide high quality services and treatment to individuals with mental illness and, simultaneously, draw down significant amounts of federal money to help pay for that care. However, although planning for future inpatient psychiatric services should be creative, it should proceed with the understanding that, in this area of complexity and uncertainty resulting from the fact-specific nature of applications of the IMD exclusion, the State, as the primary administrator of the state program, bears the risk of any improper payments to providers, i.e., reimbursements subsequently disallowed under the IMD exclusion.\textsuperscript{22}

\textsuperscript{22} \textit{Indiana Department of Public Welfare}, DAB No. 1294 (1992) (state bears the risk for improper payments to providers, even if overpayments were made in part because the federal government erroneously certified a facility as a hospital rather than as a psychiatric hospital).
Appendix #7. Issue Brief to Congressional Delegation

Nov. 9, 2006

Briefing for Congressional Delegation on
The VSH, the Futures Plan, and the IMD Exclusion

Summary of Major Issues and Requests

The Vermont State Hospital (VSH) is undergoing significant changes and the State is prepared to make substantial investments to improve the quality and accessibility of psychiatric inpatient and community-based care. The State seeks assistance from its Congressional delegation regarding the following three areas:

1. The decertification of the VSH costs the State an estimated $9 million per year. Although the long-term plan is to close the VSH by 2012, recertification of the current facility is crucial as an interim measure. The Centers for Medicare and Medicaid Services (CMS) has not been clear regarding the possibility of and requirements for recertification in the current facility for the interim. Greater specificity is sought. If recertification is achieved, Vermont believes it can draw down federal Medicaid dollars for inpatient psychiatric care under the Global Commitment waiver, which expires in 2010.

2. In regard to a new facility, federal Medicaid dollars may not be available because of the long-standing Institution for Mental Diseases (IMD) exclusion. Vermont seeks, in order of priority:
   - Repeal of the Medicaid IMD exclusion. Such repeal would reconcile federal financing with the prevailing view that inpatient psychiatric care is no longer believed to be, as it once was, custodial in nature. Instead, it is viewed as therapeutic “medical assistance,” and thus should be reimbursable. That said, repeal is probably unlikely because of the cost to the federal government. (Also, the Bush Administration has been rescinding, not extending, waivers of the IMD exclusion, as Medicaid waivers have come up for renewal.)
   - An exception to the IMD exclusion for small states, such as Vermont. The rationale supporting such an exception is that small states have fewer choices in terms of partnering with general hospitals for the provision of inpatient psychiatric care. Like Vermont, some smaller, rural states have only one hospital large enough to absorb a substantial inpatient psychiatric population without triggering the IMD exclusion. Limited options leave States in an unfair negotiating position.
   - A modified exception to the IMD exclusion for small states, such as Vermont, allowing them to partner with multiple private hospitals and also maintain some degree of ownership and control over the provision of inpatient psychiatric care. Assuming a blanket exception to the IMD exclusion is not possible, it would be reasonable to establish an exclusion that allows States some flexibility in providing inpatient psychiatric care.
At a minimum, Vermont seeks clarity on the level of clinical and financial integration with a private, general hospital that the State must achieve to avoid classification of the psychiatric “unit” or “ward” as an IMD. The federal regulations, guidance, and case law on this subject offer general parameters but leave room for uncertainty. Vermont would like to continue long-term planning without the risk of incurring unanticipated costs because the IMD exclusion is inadvertently triggered. (For details, see attached memorandum on the IMD exclusion.)

3. Although this is just one of many legislative priorities, federal earmarks to assist with implementation of the Futures Plan would be useful in the long run.

The following is background information related to the VSH and the three above-referenced priorities for Congressional assistance.

History of the VSH

The VSH is a 113-year-old institution for psychiatric care, classified as an IMD. At its peak, in 1952, the average daily census was 1,350 patients. Innovations in the treatment of mental illness combined with changes in social policy caused significant growth in community-based programs beginning in the 1960’s and the VSH was downsized commensurately. Funds previously used to support the hospital were matched with money from the federal Medicaid program to support community programs. These community services and supports have continued to grow, allowing almost all individuals who experience mental illness to lead full, productive lives in the community. Between 2000 and 2006, the average daily in-house census at the VSH stabilized at 48-51.

The Current VSH: The Population and the Facility

The VSH offers both short and long term care; there are just over 200 admissions and discharges annually. The most frequent length of stay is sixty-eight days; while the average length of stay (impacted by outliers) is one year and four months. The VSH plays a unique safety net function in Vermont’s overall system of care; it historically has provided care to individuals with higher acuity or greater risk for dangerous behavior, and to individuals requiring long term stays or involuntary medications.

In addition, there are a number of forensic admissions to the VSH. Forensic admissions refer to court-ordered observation evaluations that are performed in an inpatient setting. Admissions for observation occur when a district court sends a criminal defendant to the VSH for a psychiatric evaluation. Over the past 10 years, forensic admissions account for between 30 and 50 percent of all admissions to the VSH. Analysis of the clinical needs of individuals referred to the VSH for court-ordered observation evaluations show that this group was no more likely to be violent or in need of different or less treatment than those patients referred to the VSH through the civil admission process. Thus, there
appears to be little justification for creating separate programs associated with forensic and non-forensic admissions.

Vermont is committed to investing in renovations at the VSH with the goal of optimizing patient safety and care immediately. Nevertheless, the current facility has significant structural impediments to providing the level of high quality inpatient treatment the State ultimately is seeking. For example, the buildings are old and the rooms narrow, with poor heating and ventilation systems. All units are cramped and there are no comfortable places for family visiting, program activities or physical activity. The space for patients to meet with professional staff, for individual counseling, for instance, is also inadequate. There is little natural lighting in rooms or hallways, and the hallways are too narrow to allow for the transfer of restrained patients on regular beds; bath and toilet facilities are not available in the rooms, but are in one location with multiple toilets and showers. Accordingly, while Vermont needs to make immediate improvements at the VSH for the safety and well being of the current staff and patient population, replacement of the hospital is inevitable.

Decertification and Recertification

Vermont’s emphasis on community treatment unfortunately resulted in the unintended under-funding of the VSH. The hospital lost its certification from CMS in September 2003 following two patient suicides and a series of failed inspections. The hospital regained certification briefly in November 2004, but was again decertified in early February 2005 following the unauthorized absences of two patients while off campus. The State is committed to achieving recertification in the current facility as an interim measure, and is presently seeking details from CMS on the specific requirements and timeline of that process.

Department of Justice Investigation and Settlement

In 2004, following decertification, and pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), the United States Department of Justice (DOJ) investigated the VSH and found violations of patients’ rights with the use of restraint, seclusions, and in treatment planning. In July 2006, however, the DOJ and Vermont entered into a Settlement Agreement, conditionally ending the federal litigation. Details of the investigation, findings, and settlement are as follows.

In September 2004, the DOJ found that the VSH facility, and treatment services provided therein, denies patients their rights under the United States Constitution and federal statutory law. Specifically, the DOJ cited violations of the Equal Protection Clause of the Constitution and the Americans with Disabilities Act.

In the Findings Letter, dated July 5, 2005, DOJ attorneys noted, “the physical structure of the building is more prison-like than supportive of patient dignity and right to treatment in an environment that is conducive to treatment and recovery. While neither the
Constitution nor federal statutes require any sort of bright or lush surrounding, an expert consultant’s observation is worth noting:

“The conditions of the physical plant . . . are dehumanizing. No one should expect individuals to achieve recovery when they have to reside in a jail-like setting, sleeping right next to their uncovered toilets and having no functional closet space for their belongings.”

The Department of Justice also found that the clinical services at the VSH violate patients’ constitutional rights, stating that “the conditions and services at the VSH substantially depart from generally accepted standards of care.” In particular, DOJ found that

“VSH fails to: (1) protect patients from harm and undue restraints; (2) provide adequate psychiatric and psychological services; and (3) ensure adequate discharge planning and placement in the most integrated setting appropriate to each patient’s individualized needs.”

DOJ also found that the VSH’s risk management quality assurance systems substantially depart from professional standards of care, and noted that these deficiencies expose patients to an unreasonable risk of harm. DOJ has required that: “VSH develop and maintain an integrated system to monitor and assure quality of care across all aspects of care and treatment.”

For example, the VSH must create a quality assurance and risk management system that incorporates adequate methods for data capture, retrieval, and statistical analysis to identify and track trends in patient treatment. Although the VSH has already made improvements in these systems, and has every intention of complying with the DOJ agreement, these changes truly require integration with a larger hospital environment. In addition to improving clinical quality, integration will allow Vermont to leverage the sophisticated data and quality assurance systems already in place at its healthcare institutions and will avoid the need to create duplicate systems.

On July 21, 2006, the United States filed suit against the State of Vermont. In its complaint, the DOJ asked the federal Court to enjoin the State from violating patient’s rights through its operation of the VSH, but also asked the Court to conditionally dismiss the complaint because Vermont, in a Memorandum of Agreement, had agreed to make significant changes to the services and structure at the hospital. If Vermont is unable to comply with the terms of the agreement, the U.S. Attorney General is empowered to ask the Court to compel the State to make the necessary changes.

Under the Settlement Agreement, the State is required to make specific improvements to the VSH to correct conditions and practices that may violate federal constitutional and statutory law. In addition, two clinical experts, Dr. Mohamed El-Saabawi and Dr. Jeffrey Geller, were appointed to monitor Vermont’s compliance. Over a four-year period, Dr. El-Saabawi and Dr. Geller, along with DOJ attorneys, will regularly assess the State's
ongoing efforts to meet criteria which aim to maintain and improve the quality of care at the VSH. These criteria fall into the following areas: integrated treatment planning, mental health assessments and services, discharge planning, documentation, seclusion and restraint, emergency involuntary medication, incident management, quality improvement and environmental conditions.

**Financing the VSH: Recertification and the IMD Exclusion**

Under federal law, Medicaid does not reimburse services at Institutions for Mental Diseases (IMDs) for individuals between the ages of 21 and 65: the Medicaid IMD exclusion. An IMD is defined as a free-standing hospital of more than 16 beds that is designed primarily for psychiatric care. The exclusion is a legacy of two historic trends: first, the historic responsibility of states to provide for institutional care, and secondly, the belief that the inpatient treatment of mental illness requires an asylum or institutional rather than medical approach.

Under the terms of Vermont’s previous 1115 Medicaid waiver, Vermont negotiated an exception to the IMD exclusion in 1995 to allow the State to include a portion of the costs of the VSH under the managed Medicaid program for Vermonters eligible for services in Community Rehabilitation and Treatment programs (CRT). The federal government, however, initiated a rescission of this waiver of the IMD exclusion over a two year period ending in January 2006.

Consequently, although decertification made the VSH ineligible for Medicaid payments in February 2005, the State was due to lose all Medicaid payment under the renewal terms of the 1115 waiver by early 2006. The State negotiated the Global Commitment waiver which began in October 2005. Under the Global Commitment, the Managed Care Organization is able to make payments to “certified” providers. Below is a summary of the VSH funding and the impact in terms of lost federal participation associated with decertification.

**Actual Spending for VSH**

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<th>SFY 03</th>
<th>SFY 04</th>
<th>SFY 05</th>
<th>SFY 06</th>
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<td>$4,883,113</td>
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<tr>
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<td>62.46%</td>
<td>36.12%</td>
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<td>$0</td>
<td>($2,160,000)</td>
<td>($7,200,000)</td>
<td>($8,300,000)</td>
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</table>

If recertification is achieved, then an allowance of Medicaid receipts can be made under the Global Commitment waiver for the duration of the waiver through September 2010, despite the fact that VSH is an IMD. Hopefully extension of the Global Commitment waiver would also allow federal support for a recertified VSH in the interim while an alternative facility is constructed. Under the current Futures Plan, a new facility is unlikely to be up and operating until 2012 at the earliest. This means, without recertification, another four years without federal Medicaid support. Conservatively, it is
estimated that $35 to $40 million of federal Medicaid matching funds will be lost without certification of the VSH in the interim (SFY08 through SFY11) while an alternate facility is developed.

The Futures Plan

In the Spring of 2006, the Administration with legislative support developed a Vermont Mental Health Futures Plan that calls for new investments in the essential community capacities, along with reconfiguration of the existing 54-bed inpatient capacity at the VSH into a new array of inpatient, rehabilitation, and residential services for adults. This plan is consistent with Vermont’s long history of establishing strong community support systems and reducing reliance on institutional care. The fundamental goal is to support recovery for Vermonters with mental illnesses in the least restrictive and most integrated settings.

Clearly, one of the more critical aspects of the Futures Plan relates to inpatient services. The plan proposes 50 new inpatient treatment beds at two new levels of inpatient care, “intensive care” and “specialized care,” reflecting more intensive staffing patterns, flexibly scalable environments, and specialized clinical programming.

Though financial constraints may require consideration of alternatives, the current preferred option is a single primary program created with Fletcher Allen Health Care (FAHC). In addition, both Retreat Healthcare in Brattleboro and Rutland Regional Medical Center (RRMC) have agreed to enhance their capacity to develop specialized care inpatient programs, which will assist geographic access to specialized inpatient care and will provide the entire system with needed surge capacity.

There are several advantages to operating the new inpatient programs with host hospitals. In the case of FAHC and RRMC the advantages include:

- Integration with tertiary and community hospital health care services, including access to the full array of diagnostic and treatment services; this is important for the medical treatment of current VSH patients and will become even more important in the future as medical treatments for mental illness advance.
- Operating efficiencies and economies of scale for lab, pharmacy, medical records, food service, IT, quality assurance, and other administrative and clinical functions.
- The opportunity for federal Medicaid participation in the ongoing costs of care as neither FAHC or RRMC are IMDs.

The major disadvantages of the Fletcher project are its potential cost and the uncertainty as to whether it could come into being.

- In a state which has a $49 million annual capital spending cap for all state capital projects means an $80 to $100 million capital expense for the hospital is difficult to say the least.
- Even if a financially feasible project could be developed with Fletcher Allen, the project will have to go through a regulatory process (the certificate of need process, which was initiated August 2006) that will be difficult. To date, that process has already attracted a large number of interveners opposed to the project.
- In addition, it is unclear just how much, if any, ownership and control the State can maintain over inpatient psychiatric services without triggering the IMD exclusion. (See attached memorandum for details.)

As far as other components of the Futures Plan are concerned, they include: creation of two residential recovery and secure residential treatment programs; augmentation of the existing network of crisis beds for stabilization and diversion; development of a care management program; and additional resources for peer programming, supportive housing, and legal services.
2006 Report of the Mental Health Oversight Committee

Senator James Leddy, Co-Chair                                        Representative Michael Fisher, Co-Chair

Senator Philip Scott                                                Representative Anne Donahue

Senator Diane Snelling                                              Representative Gail Fallar

Senator Jeanette White                                              Representative Pat O’Donnell