VNAs of Vermont
Your Nonprofit
Home Health & Hospice Agencies

Final Legislative Report
May 22, 2017

State Fiscal Year 2018 (SFY2018) Budget
The final budget bill includes an increase for home health agencies and other community-based providers, along with some policy language on Choices for Care of interest to VNAs. In terms of dollars, the bill provides for the following:

- $1,410,842 for a 2% rate increase to all Choices for Care community-based providers, including home health agencies
- $360,000 for a 2% rate increase to home health agencies for all other Medicaid programs
- $68,484 for a 2% increase for meals on wheels
- $40,925 for a 2% increase for adult day rehabilitation
- $8,370,000 to increase wages at community mental health centers

Key policy provisions include the following:

- A directive to the Agency of Human Services to consider how best to "**align care coordination**" across programs; and

- a directive to the Agency of Human Services **to inventory and prioritize community grants**. This is in response to a proposal in the House to cut these grants in favor of other budget priorities; and

- a directive to the Commissioner of the Department of Disability, Aging and Independent Living to recommend an **allocation for Choices for Care program savings** available at the end of fiscal year 2017 in time for a report to the September meeting of the legislative Joint Fiscal Committee. The VNAs of Vermont are very appreciative that the Commissioner allocated similar savings in 2016 in rate enhancements to Choices for Care providers. The commissioner is also directed to recommend a permanent mechanism for allocation of these dollars. Since the inception of the Choices for Care program, language has been passed as part of the budget each year rather than codifying a method in statute; and

- a directive to the Agency of Human Services to **estimate the budgetary impact of raising wages at community mental health centers to $15 per hour and the salaries of clinical staff to be comparable to other Vermont health care positions.** The VNAs of Vermont are supportive of improving the ability of community health providers to offer wages, salaries and benefits that are competitive to other employers. We will advocate that any consideration of such issues for mental health agencies include other community providers who face similar recruitment and retention pressures and;

- funding to continue supporting the health care reform oversight committee, a joint

committee of the Senate and House that meets between sessions. The committee will be comprised of the chairs of all four money committees and the chairs of the House Committee on Health Care; the Senate Committee on Health and Welfare; the House Committee on Human Services; and the Senate Committee on Economic Development, Housing and General Affairs.

The relevant policy provisions are excerpted at the end of this document.

Home Health Provider Tax Formula
The final miscellaneous tax bill, H.516, includes the VNAs of Vermont-supported adjustment to the home health provider tax formula. The language is excerpted at the end of this document.

Provider taxes are a fraught issue for trade associations. When policymakers require "revenue neutral" proposals, some members inevitably benefit and some members are hurt by any formula change. To mitigate the "winners and losers" problem, the VNAs of Vermont called on lawmakers to provide an inflationary Medicaid increase and freeze the amount of revenue generated by the tax at FY2017 levels. The House Committee on Ways and Means eliminated the inflationary increase from the bill because budget decisions are in the purview of the House Committee on Appropriations. Ways and Means also declined to freeze the provider tax. The final bill, however, includes a sunset on the entire home health provider tax in two years, which will force a reconsideration of the issue. While this provision fails to provide immediate tax relief to home health providers, it does help lay the groundwork for a renewed advocacy effort over the next two years.

Employer Mandates
The House Committee on General, Housing and Military Affairs spent much of the first half of the session considering several new employer mandates, including an increase in the minimum wage, paid family leave funded by a payroll tax and accommodations for pregnant workers.

The committee heard a lot of testimony on several proposals to increase the **minimum wage** and then suspended their work on the bill. The VNAs of Vermont expect a minimum wage bill to arise again in the 2018 legislative session. S.135, the economic development bill, creates a legislative minimum wage study committee to develop report by December 1, 2017.

At about the mid-point of the legislative session, legislative leaders began referring to H.196, the **paid family leave bill** as a "two-year" effort. As introduced, the legislation would have funded a statewide paid family leave insurance program through a payroll tax shared by employers and employees. That proposal fizzled when the Joint Fiscal Office released an estimate of the impact on the state budget to cover Vermont state employees. As a result, the House-passed version of the legislation limits the tax to a .141 percent tax on employees to fund 12 weeks of paid leave for the birth of a child, a serious personal illness or care for a seriously ill family member.

A bill to require employers to "make accommodations" for **pregnant workers** (H.136, now Act 21) passed both the House and Senate and was signed by the Governor in early May.

Employer mandates place VNAs and other providers that depend almost exclusively on publicly financed insurance in a difficult position. Unless new employer mandates are accompanied by Medicaid increases to fund them, VNAs have few options for implementation. Medicare has cut reimbursement for VNAs by

3.5 percent each year for the last four years, and more cuts are expected. Medicaid reimbursement over the last decade has failed to keep pace with inflation. Between now and the FY2018 legislative session, the VNAs of Vermont will promote legislative language that would obligate Medicaid increases to fund new employer mandates.

Health Care Reform
OneCare, a Vermont Accountable Care Organization (ACO) and the Office of the Health Care Advocate (HCA) mutually agreed on language that passed as part of S.4, a bill that will make ACO board meetings more open to public input.

The House Committee on Health Care worked with the Green Mountain Care Board and the Department of Vermont Health Access (DVHA) on a last-minute committee bill that became H.507, designed to increase "accountability" to the lawmakers regarding the all-payer model and the Medicaid risk pilot projects in which four hospitals are participating. The bill was signed by the Governor in early May and enacted as Act 25. The bill requires the Green Mountain Care Board to provide status reports to the legislature and Office of the Health Care Advocate on the implementation of the Medicaid ACO pilot project. The bill reflects a pervasive anxiety among lawmakers about ACOs. One concern often raised by the HCA and lawmakers is that payment reform will lead providers to deny necessary care to patients to save money. In response to this concern, last year, Act 139 of 2016 directed the Green Mountain Care Board to develop regulations that would govern the behavior of ACOs. Another concern is the idea that ACOs are "monopolies" with too much power. The VNAs of Vermont view this issue quite differently. ACOs create a legal structure that allows providers to integrate and collaborate on patient care while maintaining autonomous governance.

Mental Health and Substance Abuse
S.133 was passed in response to the ongoing predicament of individuals in mental health crisis waiting for long periods of time in hospital emergency departments. The bill directs the Agency of Human Services to study many possible contributing factors and solutions and report to the committees of jurisdiction by December 15, 2017.

Miscellaneous Bills
Several weeks ago, the Senate passed S.50, a bill that expands **telemedicine reimbursement** to care provided outside of "facilities," including in the home. The VNAs of Vermont supported the legislation and raised the question of reimbursement to home care providers to facilitate telemedicine visits. At the request of the VNAs of Vermont, the House Committee on Health Care has asked the VNAs of Vermont and Vermont payers to consider the issue and make recommendations in advance of the 2018 legislative session.

Early in May, the House and Senate agreed on a final version of S.3, a legislative remedy to the confusion wrought by the 2016 Vermont Supreme Court ***Kuligoski v. Brattleboro Retreat*** **decision**. The decision significantly broadened the scope of circumstances that obligate a provider to violate a patient's confidentiality and "warn" others that an individual might pose a danger to them. It also increased the expectations on caregivers. A broad coalition of stakeholders representing providers and mental health advocates worked together to pass S.3.

H.508 creates a joint legislative **adverse childhood experiences** working group. The working group is charged with "investigating, cataloguing, and analyzing existing resources to mitigate childhood trauma, identify populations served and examine structures to build resiliency."

H.265, now Act 23 was signed into law by Governor Scott in early May. This act updates the **Long-Term Care Ombudsman statutes** to conform to the federal Older Americans Act and related federal regulations. It also creates a new private right of action for a vulnerable adult who has been the victim of financial exploitation.

Care Coordination

Sec. E.300.16 AGENCY OF HUMAN SERVICES; ALIGNMENT OF CARE COORDINATION EFFORTS

(a) The Secretary of Human Services shall conduct a comprehensive review of the Agency's care coordination efforts, including the Vermont Chronic Care Initiative, the Blueprint for Health, the pediatric High Tech Home Care program, and Community Rehabilitation and Treatment, in order to align care coordination services across the Agency's programs and initiatives, reduce duplication of efforts, and ensure that care coordination services are delivered in a consistent manner in order to achieve the best results for Vermonters and to use resources efficiently.

Community Grant Inventory and Prioritization

Sec. E.300.17 COMMUNITY GRANT INVENTORY AND PRIORITIZATION

(a) On or before January 1, 2018, the Secretary of Human Services shall submit a report to the House and Senate Committees on Appropriations identifying grants to community partners funded by the General Fund, special funds, or Global Commitment. The report shall prioritize the grants and specify whether the grant provides a match required for federal funding other than Medicaid. The report shall also provide the impact of reducing the funding level of any grants in terms of:

(1) impacts on the safety and welfare of vulnerable Vermont residents;

(2) impacts on the Agency's other community partners;

(3) how a reduction fits within existing statutory guidelines; and

(4) minimizing or avoiding any shift in cost to another department or program of the Agency of Human Services, to another agency or program of State government, or to local government or public schools caused by a grant reduction.

Choices for Care

Sec. E.308.1 CHOICES FOR CARE

(a) In the Choices for Care program, "savings" means the difference remaining at the conclusion of fiscal year 2017 between the amount of funds appropriated for Choices for Care, excluding allocations for the provision of acute care services, and the sum of expended and obligated funds, less an amount equal to one percent of the fiscal year 2017 total Choices for Care expenditure. The one percent shall function as a reserve to be used in the event

of a fiscal need to freeze Moderate Needs Group enrollment. Savings shall be calculated by the Department of Disabilities, Aging, and Independent Living and reported to the Joint Fiscal Office.

(1) It is the intent of the General Assembly that the Department of Disabilities, Aging, and Independent Living only obligate funds for expenditures approved under current law.

(b)(1) Any funds appropriated for long-term care under the Choices for Care program shall be used for long-term services and supports to recipients. In using these funds, the Department of Disabilities, Aging, and Independent Living shall give priority for services to individuals assessed as having high and highest needs and meeting the terms and conditions of the Choices for Care program within the Global Commitment waiver.

(2)(A) First priority for the use of any savings from the long-term care appropriation after the needs of all individuals meeting the terms and conditions of the waiver have been met shall be given to home- and community-based services.

(B) Savings either shall be one-time investments or shall be used in ways that are sustainable into the future.

(C) The Department may allocate savings between home- and community-based provider rates, base funding to expand capacity to accommodate additional enrollees in home- and community-based services, and equitable funding of adult day providers, including whether some amount, up to 20 percent of the total savings, should be used to increase provider rates. The Department shall provide a report to the House Committee on Human Services and to the Senate Committee on Health and Welfare on the use of savings.

(D) Savings may also be used for quality improvement purposes in nursing homes but shall not be used to increase nursing home rates under 33 V.S.A. § 905.

(E) The Department of Disabilities, Aging, and Independent Living shall not reduce the base funding needed in a subsequent fiscal year prior to calculating savings for the current fiscal year.

(c) The Department, in collaboration with Choices for Care participants, participants' families, and long-term care providers, shall conduct an assessment of the adequacy of the provider system for delivery of home- and community-based services and nursing home services. On or before October 1, 2017, the Department of Disabilities, Aging, and Independent Living shall report the results of this assessment to the House Committees on Appropriations and on Human Services and the Senate Committees on Appropriations and on Health and Welfare in order to inform the reinvestment

of savings during the budget adjustment process.

(d) The Commissioner shall determine how to allocate any Choices for Care program savings available at the end of fiscal year 2017 and shall report to the Joint Fiscal Committee at the regularly scheduled September 2017 meeting on these allocations.

(e) Concurrent with the procedures set forth in 32 V.S.A. § 305a, the Joint Fiscal Office and the Secretary of Administration shall provide to the Emergency Board their respective estimates of caseloads and expenditures for programs under the Choices for Care program.

Sec. E.308.2 CODIFICATION OF CHOICES FOR CARE ANNUAL SAVINGS

(a) The Department of Disabilities, Aging, and Independent Living shall make a recommendation to codify the process of determining, allocating, and dispersing any Choices for Care annual savings with its fiscal year 2019 budget presentation.

Community Mental Health Center Wages and Salaries

Sec. E.314.1 DESIGNATED AND SPECIALIZED SERVICE AGENCY EMPLOYEE WAGES

(a) A total of $8,370,000 appropriated in Secs. B.314 (Mental Health) and B.333 (Developmental Services) shall be used to increase payments to the designated and specialized service agencies in fiscal year 2018.

(b) It is the intent of the General Assembly that funds allocated in subsection (a) of this section for increased payments to the designated and specialized service agencies in fiscal year 2018 be used to fund or offset the costs of increasing the hourly wages of workers to $14 and to increase the salaries for crisis response and crisis bed personnel in a manner that advances the goal of achieving competitive compensation to regionally equivalent State, health care, or school-based positions of equal skills, credentials, and lengths of employment. It is the sole responsibility of each individual designated and specialized service agency to use the revenue from increased Medicaid payments allocated in subsection (a) of this section to fund increases to worker salaries.

(c) To the extent that sufficient funds are unavailable to further the purposes of this section, the designated and specialized service agencies, in consultation with the Departments of Mental Health and of Disabilities, Aging, and Independent Living, shall reduce services or other operations in proportion to the amount necessary to achieve increased hourly wages. The funding of crisis services shall remain a priority and shall not be compromised as a result of other necessary reductions in services.

Sec. E.314.2 FISCAL YEAR 2019 BUDGETING FOR DESIGNATED AND SPECIALIZED SERVICE AGENCIES

(a) The Secretary of Human Services, in consultation with the Departments of Mental Health and of Disabilities, Aging, and Independent Living, shall estimate the levels of funding necessary to sustain the designated and specialized service agencies' workforce, including increases in the hourly wages of workers to $15, and to increase the salaries for clinical employees and other personnel in a manner that advances the goal of achieving competitive compensation to regionally equivalent State, health care, or school-based positions of equal skills, credentials, and lengths of employment; enable the designated and specialized service agencies to meet their statutorily mandated responsibilities and required outcomes; identify the required outcomes; and establish recommended levels of increased funding for inclusion in the fiscal year 2019 budget.

(b) The Commissioner shall submit the estimates calculated pursuant to subsection (a) of this section on or before December 15, 2017 to the House Committees on Appropriations and on Health Care and to the Senate Committees on Appropriations and on Health and Welfare.

* * * Health Care Provisions; Home Health Agency Provider Tax * * *

Sec. 18. 33 V.S.A. § 1951 is amended to read:

§ 1951. DEFINITIONS

As used in this subchapter:

(1) "Assessment" means a tax levied on a health care provider pursuant to this chapter.

(2)(A) "~~Core home~~ Home health ~~care~~ services" means any of the following:

(i) those medically necessary, intermittent, skilled ~~nursing, home health aide, therapeutic, and personal care attendant services, provided exclusively in the home by home health agencies. Core home health services do not include private duty nursing, hospice, homemaker, or physician services, or services provided under early periodic screening, diagnosis, and treatment (EPSDT), traumatic brain injury (TBI), high technology programs, or services provided by a home for persons who are terminally ill as defined in subdivision 7102(3) of this title~~ home health services provided by Medicare-certified home health agencies of the type covered under Title XVIII (Medicare) or XIX (Medicaid) of the Social Security Act;

(ii) services covered under the adult and pediatric High Technology Home Care programs as of January 1, 2015;

(iii) personal care, respite care, and companion care services provided through the Choices for Care program contained within Vermont's Global Commitment to Health Section 1115 demonstration; and

(iv) hospice services.

(B) The term "home health services" shall not include any other service provided by a home health agency, including:

(i) private duty services;

(ii) case management services, except to the extent that such services are performed in order to establish an individual's eligibility for services described in subdivision (A) of this subdivision (2);

(iii) homemaker services;

(iv) adult day services;

(v) group-directed attendant care services;

(vi) primary care services;

(vii) nursing home room and board when a hospice patient is in a nursing home; and

(viii) health clinics, including occupational health, travel, and flu clinics.

(C) The term "home health services" shall not include any services provided by a home health agency under any other program or initiative unless the services fall into one or more of the categories described in subdivision (A) of this subdivision (2). Other programs and initiatives include:

(i) the Flexible Choices or Assistive Devices options under the Choices for Care program contained within Vermont's Global Commitment to Health Section 1115 demonstration;

(ii) services provided to children under the early and periodic screening, diagnostic, and treatment Medicaid benefit;

(iii) services provided pursuant to the Money Follows the Person demonstration project;

(iv) services provided pursuant to the Traumatic Brain Injury Program; and

(v) maternal-child wellness services, including services provided through the Nurse Family Partnership program.

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(10) "Net ~~operating~~ patient revenues" means a provider's gross charges related to patient care services less any deductions for bad debts, charity care, contractual allowances, and other payer discounts.

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Sec. 18a. 33 V.S.A. § 1955a is amended to read:

§ 1955a. HOME HEALTH AGENCY ASSESSMENT

(a)(1) ~~Beginning October 1, 2011, each~~ Each home health agency's assessment shall be ~~19.30~~ 4.25 percent of its net ~~operating~~ patient revenues from ~~core~~ home health ~~care~~ services~~, excluding revenues for services provided under Title XVIII of the federal Social Security Act; provided, however, that each home health agency's annual assessment shall be limited to no more than six percent of its annual net patient revenue~~ provided exclusively in Vermont.

(2) On or before May 1 of each year, each home health agency shall provide to the Department a copy of its most recent audited financial statement prepared in accordance with generally accepted accounting principles. The amount of the tax shall be determined by the Commissioner based on the home

health net patient revenue attributable to services reported on the agency's ~~most recent audited~~ financial ~~statements~~ statement ~~at the time of submission, a copy of which shall be provided on or before May 1 of each year to the Department~~.

(3) For providers who ~~begin~~ began operations as a home health agency after January 1, 2005, the tax shall be assessed as follows:

~~(1)~~(A) Until such time as the home health agency submits audited financial statements for its first full year of operation as a home health agency, the Commissioner, in consultation with the home health agency, shall annually estimate the amount of tax payable and shall prescribe a schedule for interim payments.

~~(2)~~(B) At such time as the full-year audited financial statement is filed, the final assessment shall be determined, and the home health agency shall pay any underpayment or the Department shall refund any overpayment. The assessment for the State fiscal year in which a provider commences operations as a home health agency shall be prorated for the proportion of the State fiscal year in which the new home health agency was in operation.

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Sec. 18b. 2016 Acts and Resolves No. 134, Sec. 32 is amended to read:

Sec. 32. HOME HEALTH AGENCY ASSESSMENT FOR FISCAL ~~YEARS~~ YEAR 2017 ~~AND 2018~~

Notwithstanding any provision of 33 V.S.A. § 1955a(a) to the contrary, for fiscal ~~years~~ year 2017 ~~and 2018~~ only, the amount of the home health agency assessment under 33 V.S.A. § 1955a for each home health agency shall be 3.63 percent of its annual net patient revenue.

Sec. 18c. TRANSITIONAL PROVISION FOR FISCAL YEAR 2018

Notwithstanding any provision of 33 V.S.A. § 1955a(a)(2) to the contrary, for fiscal year 2018 only, the Commissioner of Vermont Health Access may determine the amount of a home health agency's provider tax based on such documentation as the Commissioner deems acceptable.

Sec. 18d. REPEAL

33 V.S.A. § 1955a (home health agency assessment) is repealed on July 1, 2019.

* * * Sales and Use Tax; Aircraft * * *

Sec. 19. 32 V.S.A. § 9741(29) is amended to read:

(29) Aircraft, but not drones, sold to a person which holds itself out to the general public as engaging in air commerce, for use primarily in the