Vermont Care Partners

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Legislative Update February 12, 2018

Upcoming Advocacy Events

Community-Based Public Hearings on the Governor's Recommended FY2019 State Budget
The Vermont House and Senate Committees on Appropriations are seeking public input on the Governor's Recommended FY2019 State Budget and will hold community-based public hearings on **Monday, February 12, 2018, 6:00 – 7:00 p.m. at the following 6 locations:**

- Johnson State College – Stearns Student Center, Performance Space, 2nd Floor in Stearns
- Rutland City – Rutland Public Schools, Longfellow School Building, Board Room
- St. Johnsbury – St. Johnsbury House, Main dining room, 1207 Main St.
- St. Albans City – St. Albans City School, Library, 29 Bellows St.
- Winooski - Community College of Vermont, Room 401, 4th Floor.
- **NEWLY Added: Springfield** – Springfield Town Hall, 96 Main Street, 3rd Floor Conference Room (Selectmen's Hall) **5:30-6:30 p.m.**

An additional public hearing will be held on Tuesday, February 13, 2018, 6:00 – 7:00 p.m. in room 11 of the State House in Montpelier.

The Committees will take testimony on the Governor's recommended State budget at the above dates and times. Anyone interested in testifying should come to one of the hearings. Time limits on testimony may apply depending on volume of participants. If you have a story you would like to share privately with the committee members, please contact Theresa to schedule this at the end of one of the hearings.

For more information about the format of these events, or to submit written testimony, contact Theresa Utton-Jerman, tutton@leg.state.vt.us or Rebecca Buck, rbuck@leg.state.vt.us or at 802-828-5767 or toll-free within Vermont at 1-800-322-5616.

Legislative Action

House Appropriations Committee Takes Testimony from DAIL Commissioner Hutt
Commissioner Monica Hutt presented the DAIL budget to the House Appropriations Committee. Monica reviewed the mission and highlights. The GF goes up 2.5%. They added funding to cover sick leave legislation which will enable people who self-employ to cover the expense of sick leave per a statute that went into effect in January.

The Developmental Disabilities Services Division supports people to live their lives in the community, but most of them are eligible to receive services due to past institutionalization or eligibility to be institutionalized. Approximately 4,500 people are served, of which 3,070 use the Home and Community Based Services waiver. They receive a full package of services to live in the community. Other programs

include Flexible Family Funding, Bridge services, targeted case management, and employment programs. When questioned about residential options Monica said she would like to put more group homes back into the mix, for instance a couple of youth who graduate from high school who want to be roommates. Committee Chair Representative Toll asked for more information about people who have to be in a facility that would prefer a different option. Representative Fagan complemented the ICFMR's integration into the community. Monica said all the DAs do a good job in integrating the group homes.

In reviewing DS RBA outcomes Monica said we provide support to allow people to be part of their communities and be as independent as they want to be. She pointed out the job earnings data, as well. Most people live in cost effective settings: 79% are in Share Living Homes (SLPs) which meets people's need extraordinarily well. In 2016, 216 people were living independently and in 2017, 327 people were living totally independently. Monica said that this is a tribute to the work of the agencies.

Representative Toll asked about the impact of $4.3 million reduction and how DAIL will mitigate adverse impacts. Monica responded by speaking about the need for new caseload being $10 million and noted that the reduction to people who already have their services is equivalent to just a 2% cut. Monica acknowledged that he impact is real. DAIL works with agencies to determine where reductions can be made. It's an individualized process. Some individuals will not be able to sustain any reduction, so some people will have higher reductions. The reductions will be in respite, community supports and supportive employment. Monica is worried that the reductions will impact community access and employment supports. It reduces the margin for agencies to redirect funds to serve individuals with increased service needs.

When asked about how they negate negative impacts Monica said they will work with providers and trust in them to work with individuals to make the best choices. Individuals and families can appeal to the Department. Representative Toll is concerned about learning the impact of the potential cuts at the public hearings next week. How will we know if people present the cuts in an overstated way? Monica said you will hear people's worst fears and what they are most anxious about.

Representative Yacovone asked about if people didn't fully spend their budgets -should we assume that they don't need all the services. The answer was, yes. He continued, "What if we didn't get the services because we couldn't find the staff to do it? Are we going to lock people into a base that's too low due to low wages?" Representative Yacovone spoke about the SLPs who have gotten no increase for 15 years. People need the respite. Is this typical? Monica said she doesn't know if it's typical. It's not just a wage issue – it's also a workforce issue. Wage is one part of the dynamic.

Representative Yacavone asked about what drove this cut. Commissioner Hutt replied that the goal was to ensure that all budgets grow at a sustainable rate. The goal was to balance the pressures. The DS is always a big pressure. Monica ran out of other places to cut. He asked "why didn't you go to Choices for Care?" Choices for care costs only $30,000 per person per year was the reply.

Representative Lanpher said that over the decade we have not given increases to our partners. They have held the line with tight budgets. We are here again due to a target. All of these people have services in place and we are asking for reductions after the plans were based on assessed need and reviewed by the DAIL, in the leanest way possible. The excess capacity is not there. She asked, "What is the plan to monitor the loss of progress by these people?"

Monica acknowledged that there will be impacts, but they have a responsibility to have sustainable growth. The Caseload growth has been large each year. It does not address operational costs of DA/SSAs. She felt she needed to prioritize caseload need. It's already a small door to come through

with clinical and financial eligibility. Most of the eligibility criteria are crisis based. We are serving the people at the most need, so we need to sustain the system of care. "I can't sugar coat it. It is not an easy decision." She added.

Representative Trieber wanted to know about income and asset edibility and if we can look at income and assets of the total family. Monica explained Medicaid rules and said it could be challenging. Representative Yacavone, explained that the majority of people served don't live with relatives.

Representative Hooper asked if we have adequate supports to keep that system sustainable. What have we done in the past? Have we met all the demands and caseload? Have we been whittling away at it periodically? Monica said we have received full caseload funding. We put a lot of pressure in authorizing /limiting services; there has been a lot of pressure over time. Representative Hooper asked if the State provided salary increases. Monica acknowledged that there have been rescissions in the past; the last one was in 201. Part of the $10 million up is making up is the $1.5 million rescission from caseload in FY18. Representative Hooper asked, "if we go ahead and people can't make it, where do those folks go?" "If you gave them just enough – how do you decrease it?" Monica replied that for some, it won't have a profound impact. In the past, agencies have developed creative alternatives with fewer individualized supports.

Representative Yacavone expressed concern about the SLP who feel like they can't do it anymore. He said, "keep in mind many people have been in many home settings, because they have difficult needs. The people served get attached to these SLPs, there comes a time when a person might get moved, when a family can no longer provide the services. The agency then has to find a SLP who is willing to accept the $26,000. Families burn out and people served go through difficult transitions when they are placed in a new family."

Representative Lanpher wanted to know if we are we making a vulnerable population more vulnerable. Monica pointed out that the Administration is supportive in that it put forward the $10 million in caseload. She feels like it's about looking at the individuals, that's critical.

Representative Trieber asked if we would we be better off freezing the program? Monica, said we are not allowed to have a waitlist according to our System of Care Plan. Eligibility is already emergency-oriented. Deputy Commissioner Camille George reminded the Committee of Olmstead decision which would be a barrier to freezing the program.

DAIL Commissioner Monica Hutt Gives DAIL Budget Request Update to House Human Services

Commissioner Hutt gave a similar overview on the DAIL budget request to the House Human Services Committee as she did to the House Appropriations Committee. She spoke about supported decisions making and using circles of support to improve civil rights of people who have guardians. There were questions about the caseload of public guardians. Monica said that they tend to be at 35- 40, but the national standard is about 20. DAIL brought in an attorney in to train on supported decision making for guardians and providers and this led to the development of the pilots. Much of the work needs to be done by the Courts. It's not a cost savings – it's the right thing to do to allow people to make their own decisions. We shouldn't remove people's legal rights unnecessarily.

Monica said that most of DS work is done in partnership with DA/SSAs and is all funded with global commitment (GC) dollars. Theresa asked if Monica has quantified what it would cost if the people receiving residential services were to move to a staffed arrangement like a group home or staffed apartment?

She also asked about what types of supports might be reduced with the $4.3 million cut to DS waiver services. Could it include residential? Yes, Monica said, this has happened in the past. We will ask providers to work with individuals and families one-on-one. The cut is to the agencies and the impact will be to the individuals. Representative Wood said, you are funding increase case load demand and asking current recipients to cut services to fund it. Is that correct? She also asked about DAIL's response to the State Auditors report, "Will that result in additional cuts in services to bring reimbursement in line with costs?" Monica said she would categorize it as more about documentation about how services are provided. Agencies have always had the right to balance client budgets. Monica said new caseload does not relate to operational or infrastructure costs. She went on to say that they want to articulate the cost of doing business. "We have not done that well."

Theresa asked how much was the investment in salaries. The Workforce investment was intended to be a 2 year plan. Was no money in budget request for FY19? The reply was "yes". Secretary Gobeille stated that he wanted to see the impact of the $14 lift before moving to the $15 lift.

Monica acknowledged that they have not kept pace with understanding system costs. Agencies get 5% for administration for new services. To adjust it would be a big lift. It used to be that agencies would have to return full administrative costs when people left service. She concluded by saying that they need to stay on top of the accountability piece.

DMH Commissioner Melissa Bailey Presents to House Health Care

Commissioner Melissa Bailey presented a budget request overview and then responded to questions from Representative Donahue as follow-up to Act 82. Representative Donahue asked about whether DMH had set standards for emergency department (ED) waits? Monica replied in the negative and explained that across the country people with psychiatric care needs typically have long waits in EDs. The standard for ED for all care is 4 hours. Melissa said DMH does not have oversight of EDs, but they are working with VAHHS on ways to move people through. She is exploring with hospital EDs about training staff for treating people with psychiatric need.

In relation to staffing at DAs Melissa said that the workforce investment has helped stabilize workforce, but the unemployment rate is 2.9%. When asked what would be the funding resource needed to address the workforce need, it was explained that AHS addressed it through it Act 85 report. When Representative Lippert asked about stage 2 of the workforce investment Melissa confirmed that stage 2 is not in the budget.

The Committee learned that the plan to do 8 more intensive residential beds has been adjusted to expanding the Secure Residential program to 16 beds. Melissa also spoke about augmented services for geropsych. They are working with a nursing home (CLR) and UCS in Bennington to create a pilot program. There is no money for this in the DAIL budget. DMH plans to continue to explore the option and see if there is a way to enhance rates without a budget line item. Deputy Commissioner Mourning Fox said a couple of elders in VCPH had to be placed out of state because they needed a skilled nursing facility. Fox said they have already adjusted some nursing home rates for a few people discharged from VPCH. With CLR they hope they can not only take residents, but also train and support other NHs to do the same. If DMH and DAIL do identify a few people they will try to figure out a way to do it, but 12 beds would take a budget adjustment.

Forensic recommendations include: expanding secure residential, adjusting orders of non-hospitalization (ONHs) and developing street outreach to reduce criminal justice involvement to divert people from becoming forensic patients.

Recommendations on funding structures for emergency services were discussed. Melissa said DAs bill 30% as fee-for-service and 70% as GC. DMH is working with DAs on restructuring funding to move away from fee-for-service and it would be beneficial to fold emergency services in, too. This work also involves DAIL and DCF. There could be bundled payments for Kids and Adults with mental health needs. BC/BS is interested in partnering on funding models for DAs. It's not full health care integration or related to the ACO model, but they are keeping the ACO informed. DMH has a capped budget for outpatient. Folding DVHA into the bundled model creates flexibility, but doesn't solve the problem of capped services. IFS is better but not perfect. Melissa said that they are negotiating the expectations for the new payment model and existing resources.

She talked about the new SAMSHA grant for $10 million over 5 years. Its goal is to integrate DA and FQHCs for bidirectional and integrated care. It will start in two regions: St Albans and Springfield. Melissa said they are trying to reach out to families with pre-school children and will proved health care services in community mental health agencies for school-aged children. The goal is to expand to other regions in years 2 and 3. When the funding is over, the goal is to continue to fund the services in a new and better way.

They discussed the proposed temporary forensic unit. The 12 beds will not address all of the current forensic patients currently at inpatient facilities. The number is based on what is available. It will start to have an impact. There are some questions about whether the unit will really be ready for operation in FY19, although its budgeted for 3 months of operation in the Governor's request.

Number of street outreach workers? Melissa said that initially they based the request on $80,000 salary and fringe and overhead. The administration decided to only fund fringe and salary for a total of $65.000. The plan is to employ 4 people in Chittenden, plus 3 people in the 3 other counties. Chittenden went first because there is already a program up and running. In other regions the towns have not yet made commitments. Each region may take somewhat different approaches to staffing. The goal is to divert from EDs. There was a discussion about the isolation that people feel. Representative Cina said lets refer to these programs as outreach services.

Representative Lippert is not expecting a decision on the facilities plan in the context of the FY19 budget - it's too expansive to do that.

ACO Presentation to House Health Care by Michael Costa and Ena Backus

In 2016 Vermont and the federal government entered into the All-Payer ACO Model Agreement. The Agreement provides for:

- Protection of Medicare beneficiaries
- Enhanced benefits for Medicare beneficiaries attributed to ACOs;
- A six-year phased-in approach to implementation;
- Meaningful measures and targets to support population health improvement;
- Provider-led reform;
- Vermont-specific local control;
- Preservation of successful Vermont reform programs;
- No financial penalties to the State or Providers should targets not be achieved;
- Reasonable targets for limiting health care cost growth;
- Addressing the payer differential between Medicaid and Medicare
- Accountability of ACOs and oversight by the GMCB.

The GMCB must ensure that the ACO meets criteria in the following categories:

- Leadership and Governance
- Population Health Management and Care Coordination
- Performance Evaluation and Improvement
- Patient Protections and Support
- Solvency and Risk Management
- Provider Payments

Act 113 sets ACO budget review requirements for the Green Mountain Care Board. The Board must review and consider integration of efforts with Blueprint for Health, community collaboratives and providers, as well as systemic investments to strengthen primary care, address social determinants of health and address impacts of adverse childhood experiences (ACEs).

AHS is working on a public health accountability framework. Additionally, by December 31, 2020 AHS must develop a financing model for HCBS.

The VT non-profit law requires that no more than 40% of board can have a fiduciary interest. OneCare is a LLC, not a nonprofit, but the owners are nonprofits. Michael Costa, said there is oversight on how funds are spent. The motives and drives of the parent corporations are watched. UVMC, but not DHMC, is regulated by GMCB. OneCare, UVMC and Dartmouth budgets are reviewed by GMCB, too. GMCB also looks at rate increases of OneCare through review of private insurance rates. Michael Costa said CMS is not fully supportive of current model of DVHA acting as a MCO, so moving to OneCare addresses their concern. DVHA does keep thinking about plan B, if ACO model doesn't work or APM agreement were to end. In that case, DVHA would develop a value-based payment model to directly pay all providers.

When asked how the model expands across the care continuum, Michael Costa said that AHS is thinking about what they want for a new payment model. Essential elements to be ready for payment reform include data and reporting, "We need to be sure that the DAs are ready."

Representative Donahue asked if the administrative costs will go down at DVHA and insurers? GMCB will look to see if some administrative functions will be transferred to the ACO. DVHA has removed prior authorization for providers in the network.

Susan Aronoff Raises Concerns about ACOs to House Health Care

Sue Aronoff, Senior Policy Analyst of the VT Developmental Disabilities Council reported that her main concern is about Medicaid funded services and the plan for those services to be moved into the ACO under the APM. Her opinion is that:

- The All Payer ACO Agreement does not increase coverage or access.
- The All Payer ACO Agreement does not reduce the number of uninsured Vermonters.
- Regarding choice, an individual cannot "opt-out" of the ACO

Representative Donahue argued that if the growth in the cost of care is limited, then it could address access issues.

Sue raised concerns about the dual role of the GMCB of promoting and regulating the ACO. She also asserted that as a for-profit LLC:

- In the All Payer ACO Agreement, Medicaid savings accrue to the ACO instead of the State. "Savings" become OneCare's profits.
- Will the All Payer ACO initiative result in privatizing Vermont's health care system?

- OneCare is owned by 2 hospitals and operated by UVM Medical Center. Does this create conflicts of interest?
- OneCare has been given millions of dollars in grants, contracts, and public money. Is there adequate transparency? What is the public getting in return?
- There are no mechanisms to ensure that ACO savings will be used to improve, enhance, and expand services. The ACO can use any "savings" as it chooses.

Sue questioned the "Delivery System Reform Investments" of about $2 million in the Governor's FY 2019 Budget Request (DVHA UPS) to pay OneCare for infrastructure costs at the same time cuts are being made to direct services.

DVHAs Reaction on Universal Primary Care Bill

Michael Costa, Deputy Commissioner for DVHA responded to Senate Health and Welfare Committee's proposed language on universal primary care, specific to DVHAs role. In the bill DVHA is given the role reviewing implementation of the universal primary care plan. Michael is not sure what they will be evaluating and whether they have the expertise. The funding for universal primary care would be from hospital overage by collecting receipts that are in excess of budget targets for hospitals. He questioned whether the federal government would perceive it as a provider tax. Provider taxes have to be collected from all providers in a class at the same rate; It must be broad based and uniform. However, this is primarily an issue if you plan to use the fund to draw down federal funds. So DVHA is still researching this. The Safe Harbor requirement says the provider tax cannot be above 6% or there will be further analysis by the federal government. This idea is novel he said, he just wants to make sure that it doesn't wander into federal provider tax rules.

Michael also said carving benefits up between universal primary care and other insurance can be confusing to the consumers and the insurers to determine how to coordinate the benefits. He said that DVHA is also working on payment reform across the agency to achieve value-based payment. This is time consuming and impacts DVHA's limited resources.

Senate Health and Welfare Hears DMH Budget Overview from DMH

Deputy Commissioner Mourning Fox and Finance Director Shannon Thompson for DMH gave an overview to the Senate Health and Welfare Committee. They highlighted the movement of the IFS positions into DMH from AHS. Hill House has an increase for an E bed. There is a PNMI rate increase and extraordinary relief for a client who needs additional resources. They highlighted the SAMHSA grant for bi-directional care for children between FAHCs and DAs. HUD funding was lost for four programs, so replacement funds are budgeted. Additionally ABA funding, 3-months of operating for the forensic unit, and street outreach funding were reviewed.

Senate Health and Welfare S.203 Creates a Study Committee on Orders of Non-Hospitalization (ONH)

The Committee bill sets up the study committee. The powers and duties of the committee would include reviewing current law including Act 114, available data and recommending a pilot program and changes to the ONH statutes. Fox said that ONHs can be helpful or detrimental. This committee could alleviate and mitigate problems of ONHs and reduce the use of coercion in the mental health system.

Sandra Steingard, MD, Chief Medical Officer for the Howard Center said she thinks Mr. Stetson's report captures a lot of the problems of ONHs. There is a double message in how it works. She sees mental health courts as a good alternative, but a person can't go that route if found incompetent. The treatment of people, if not eligible, does not address the criminal risk. A person could meet the ONH

requirements, but continue to be at risk of criminal behavior. Currently, the DAs are put in an untenable position.

If a person comes out of the hospital and has an ONH, typically they are required to go to treatment, not abuse substances, and stay in agency approved housing. People may choose to take the drugs they want, not the drugs prescribed if the people are not dangerous. The agency is expected to specify if a person is dangerous, but agencies don't have ability, with medical authority to accurately predict danger. Sometimes the families feel like agencies drop the ball. The remedy proposed in the report is clinical treatment. Sandy says the focus of treatment is relationships. Sandy talks to people about what they want in life based on transparency and respect. Usually she and her patients agree on the goal of avoiding hospitalization, but not about how to achieve that. She suggested training for staff of DAs on best practices on engaging people. Force is not a good idea. Sandy said they tried to work with Judge Crawford when people don't comply to ONHs, by bringing people in talk to the Judge, but no one showed up.

Lt. Lamont, a state trooper from St Albans spoke about law enforcement's experience with ONHs. He has had an embedded mental health worker from NCSS for the last year and it has been very effective and helps them address when ONHs are revoked. The community has a lot of drug and mental health issues among the population.

Jack McCullough of the Mental Health Law Project said we all know that the mental health system is in crisis for a number of regions: people stuck in EDs and inpatient psychiatric care, plus coercion. The legal nature of an ONH is almost identical to commitment. One must be in danger to self or others, but that person can adequately receive treatment outside of a hospital. It's a burden on the mental health and judicial systems. MH law handles about 300 cases related to ONHs each year. Usually there are requests to extend and sometime there are request to revoke the ONH to send the person back to the hospital. There is question about whether ONHs lead to better mental health outcomes. He cited a study of ONHs which found that in well-coordinated mental health systems such measures don't reduce hospitalizations. He would like to reduce coercion. He suggested adding the mental health ombudsman to the study committee. Jack does not agree that the report of the Treatment Advocacy Center be part bill. He sees it as heavily coercion-oriented organizations. It would make the legislation less than objective. Most people come into the mental health system through the civil process.

Laurie Emerson, Executive Director of NAMI-VT said a lot of families become involved with ONHs when their loved ones do not comply. If a person chooses not to follow treatment, sometimes it's due to depression or anxiety. She recommends making sure the full continuum of care is available for people including peer support and embedded mental health workers in law enforcement. She would like to see a decrease in need for ONHs. There is challenge with DA workforce due to underfunding which impacts their ability to maintain continuity of staffing to promote therapeutic relationships. We need to look at the whole system. It's always best to have voluntary care verses coercion. She supports looking at the effectiveness of ONHs.

Devon Green, Vice President of VAHHS said strengthening the mental health system is a priority for VAHHS and they support the bill.

Wilda White, Executive Directors of Vermont Psychiatric Survivors said it was emblematic that they were not invited to testify on the bill. She believes that the people who are most impacted don't have a voice. Specifically, she said having just one peer member of the committee would be tokenism, 5 people with lived experience should be on the committee. All people with mental health conditions fear that their personal agency can be taken away from them. The only commonality people with mental

illness have, she said, is that of being discriminated against. The vast amount of people with mental illness are law-abiding, but when she comes to the legislature if feels like mental illness and criminality are conflated. People who are closest to the problem are in the best position to solve it. The real danger of ONHs is that it minimizes agency and redirects a person's focus from reclaiming their lives. People are signing off on ONHs just to get out of the hospital. She thinks these people are not necessarily refusing medication. Wilda would like to see Vermont be the first state not to have the ability to require drugs. She thinks there is a slow build up to mental health crisis, but we need to focus on keeping people well and preventing mental illness, or least providing early intervention. She went on further to say that some DAs are not utilizing best practices in getting people therapists when the need them. Wilda thinks you can force drugs on someone to control behavior, but to achieve treatment you need a therapeutic relationship.

House Education is working on version 7.1 of the Special Education Funding Bill

The House Education Committee had a wide ranging discussion on their bill regarding special education funding. Currently there are 13,000 kids with IEPs, of which 647 student meet the extraordinary needs threshold of $50,000 which costs the State $20 million. The average extraordinary needs student costs over $80.000. If threshold were $60,000 there would be 150 fewer special needs students. Families have rights to IEP services. IF House Education comes up with an arbitrary formula, it could go to court.

In small districts one student can cause substantial challenges in the budget. Dylan Giambatista is concerned that special educators will be in a difficult circumstance. Representative Emily Long is concerned about the impact on small one-school districts if they should have a few 'extraordinary cost' students. On the other hand Committee Chair Representative Sharpe said that Maine moved all special education to the state to fund and it was a disaster for containing spending. Representative Webb is concerned that we need to set incentives to contain funding.

The District Management Cost study found that we too easily just assign one-on-one services which kicks too many kids over the extraordinary spending threshold. They then discussed the need for interpreters, kids that need 2 on 1 staffing, plus additional services due to disorders like autism.

Sharpe thinks it's saleable to have a formula that give districts skin in the game up to $55,000 plus an inflation factor, with an additional payment for costs above the threshold. Representative Long said the extraordinary costs formula is for the state to meets its obligations to high needs students. It also helps school districts that have larger groups of high-needs students. Alice Miller wants the State to pay 100% of the costs above the threshold for high-needs students for those costs over the threshold. Some of the members said that the schools do have flexibility of using the census funds for special education students. The current $50,000 threshold has held even for 20 years. If you increased it by inflation the threshold would be $77,000. Sharpe said the extraordinary cost category is only 10% of school spending. Representative Webb is worried about DMG and Finance model. In the end it appeared that they landed on threshold at $60,000 with an inflator with a 90% match at above that amount. It will be studied by the workgroup they are creating.

Testimony by Dr. Mark Levine and Jolinda LaClair at House Human Services

Health Commissioner Mark Levine and Governor Scott's Opioid leader Jolinda LaClair presented testimony focused on Hub and Spoke, Recovery Centers, and SBIRT. They noted that 8,000 Vermonters actively accessing treatment right now; they believe 20-30,000 Vermonters have an opioid use disorder. 2017 overdose rates are expected to be in the same range as 2016. They are excited by new research from UVM showing efficacy of hub and spoke model.

Dr. Levine noted that there is a lot of focus on integrative pain modalities (examples, acupuncture, naturopathy, mind-body work), but not all insurance covers these interventions. In DC this week Vermont advocated for more research in this area and reform to encourage payers to cover them.

The Opioid Coordinating Council recommended a universal referral line such as 211 for accessing SUD treatment. They are excited about the "Treatment on Demand" pilot in ED settings, starting in central Vermont. The testimony focused in importance of recovery centers but noted they have "shoestring budgets;" "building capacity for infrastructure, staffing, and use of evidenced-based practices."

Jolinda LaClair noted that the workforce subgroup will focus on "supporting workers in pursuing paths to certification/licensure; increasing number of federally waivered prescribers trained to provide office-based opioid disorder treatment; and expanding opportunities for credentialed clinicians to access training. They are also establishing a workgroup to improve clinical treatment to: increase mental health services; provide services for family members/significant others; provide vocational services; review and mandate system protocols and procedures. In response to concern about transportation raised by Representative Noyes, LaClair said the Recovery Strategy Committee will be focusing on transportation and childcare.

To take action or for more information, including the weekly committee schedules:

- Legislative home page: https://legislature.vermont.gov/
- Sergeant-at-Arms Office: (802) 828-2228 or (800) 322-5616
- State House fax (to reach any member): (802) 828-2424
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- Email, home address and phone: Legislators' email addresses and home contacts may be found on the Legislature home page at https://legislature.vermont.gov/
- Governor Phil Scott (802) 828-3333 or http://governor.vermont.gov/

The purpose of the legislative update is to inform individuals who are interested in developmental, mental health and substance abuse services about legislative advocacy, policy development and activities that occur in the State Legislature. The Vermont Council is a non-profit trade association which works in partnership with Vermont Care Network to form Vermont Care Partners. Together our mission is to provide statewide leadership for an integrated, high quality system of comprehensive services and supports. Our membership consists of 16 designated developmental and mental health agencies.