VERMONT CARE PARTNERS

Supporting Vermonters to lead healthy and satisfying lives community by community

Legislative Update for March 17, 2021

The COVID 19 pandemic has changed the focus of Vermont Care Partners' advocacy efforts as our provider network has revamped our services to meet the needs of Vermonters in new ways with careful precautions for health and safety of those we serve, our workforce and partners. Legislative work is being conducted remotely.

WHAT'S HAPPENING IN THE LEGISLATURE

On January 26th Governor Scott presented his budget proposal for fiscal year 2022 (FY22) which starts July 1, 2021. The Appropriations Committees are now reviewing the budget by taking testimony from Agency Secretaries and Department Commissioners, as well as by hearing from constituents and advocates. The House Human Services Committee and House Health Care Committee have completed their requests to the House Appropriations Committee which is now developing the bill for consideration by the full House of Representatives. Soon the Senate Health Care Committee will provide input to the House and Senate Appropriations Committees on the budget relevant to designated and specialized service agencies (DA/SSAs). Differences between the House and Senate on are worked out in conference committee.

H.315 has been advanced by the House of Representatives in advance of the fiscal year 2022 budget bill for the purpose of allocating federal COVID one-time funds already received by Vermont, as well as carry forward for FY21. The Senate is considering the Bill now.

The new federal relief bill will bring a larger than anticipated infusion of funds to the State of Vermont. It may lead to adjustments in state appropriations, once there is greater clarity allowable use and restrictions of the federal fund. Most of the funds must be expended by 2024 and will not be used for funding base appropriations which continue on an annual basis.

Vermont Care Partners and network agencies are advocating for resources to meet the increasing acuity and demand for services after the Governor's budget didn't address the rate increases needed to address our workforce challenges.

The Vermont Care Partners legislative agenda is quite comprehensive and focuses on our need for adequate resources to meet our mission and mandates. See this link: https://vermontcarepartners.org/wp-content/uploads/2021/01/legislative-agenda-2021-working-draft-1.pdf

This Week's Testimony

APPROPRIATIONS AND FUNDING-RELATED LEGISLATION

Briefing on Federal Relief Funding
On March 10th Steve Klein shared information on the newest federal funding relief bill from Senator Sanders' office. The state will receive over $1.05 billion plus $113 million specifically for capital funds. Funds for counties and municipalities are included in the package but how they can be used in Vermont is unclear given that we have minimal county government. Money cannot be used for state pension systems. The date by which funds need to be spent varies based on the pot of the money. The capital funds will be available until 2024.

The specific federal guidance on how funds can be spent is yet to come out. Representative Peter Fagan asked if it will be possible to swap federal funds for general fund appropriations at a later date. Steve Klein thought it might be possible. There was a question about whether funds will be available for hotel costs for people who would otherwise be homeless which could not be answered yet. Steve also deferred on answering a question from Representative Yacavone about whether funds could be used to reduce mortgages of non-profits.

Each state will send a request for use of the funds, then the funds will come within 60 days of the request. No funds are expected to arrive in Vermont before May.

Additional Information on Federal Funding in the new federal relief package for mental health and SUD was developed by the National Council for Behavioral Health Care:
https://www.thenationalcouncil.org/wp-content/uploads/2021/03/American-Rescue-Plan-Act-MH-SUD-Provisions..pdf?daf=375ateTbd56

House Appropriations Committee Marks Up the FY22 Budget
On Friday, the Committee talked about their goals for the budget. Representative Dave Yacovone highlighted the need for a COLA for designated agencies and choices for care providers as other key safety net providers. He feels that the Governor's budget does not support safety net providers and the most vulnerable Vermonters. Dave is aiming for a 2% rate increase for Choices for Care and DA/SSAs at a total cost of $5 million. He spoke about Susan Yuan's testimony about how her son's provider has not gotten a raise for 15 years. A $847,000 GF for 2% COLA for DS rates for ($1.3 million total funds for home providers). Dave made it clear that if we don't adequately fund the COLA for community providers some people will go into nursing homes at a higher cost to the state.

Earlier in the week Dave Yacavone said that since the House Health Care Committee and House Human Services both requested COLA for DA/SSAs he is recommending that the $600,000 for the demonstration program for mobile crisis services for children in Rutland come from one-time funds instead of base funding. He is hoping that one-time funds could be used for two years. The House Health Care Committee did not recommend funding it at all. Representative Fagan said that the data shows high utilization of the emergency room for children and feels that this service is very important. Representative Yacavone kept the warmline for Pathways for housing open for consideration. He also conveyed the House Human Services Committee's recommendation that $400,000 for justice reinvestment funds be invested in the COLA and that DOC funds be used for the justice reinvestment initiative for mental health and SUD. Dave would like to invest one-time funds to support people leaving incarceration.

Chair of House Health Care Bill Lippert came to the Committee to recommend a one-time appropriation of $180,000 for H.210 the Health Disparities bill which addresses: BIPOC, LGBTQ and people with disabilities. A commission will be formed to develop recommendations on education for health providers and to form an office of health equity at the Department of Health. The funds are for:

- $20,000 for stipends for the commission;
- $20,000 for expert voices for the commission and related expenses; and
- $140,000 for a consultant to stand up and support the commission.

Representative Lippert acknowledged that the proposed office of health equity will cost money, but he has some optimism that there may be federal grant funds for that in the future. He noted that there is a cost to Vermont to not addressing health disparities. There may also be some existing funding at the Department of Health that could be invested in this initiative.

House Human Services Addresses Medicaid Reimbursement Rates for Community-based Providers

The language for H.153 came out of the choices for care bill that passed last year after this language was taken out of bill due to concerns of the Appropriations Committee. Rep Wood explained that providers have no statutory language for having their rates reviewed. They are doing the state's work and their rates are addressed in a piecemeal fashion each year. Rep Whitman shared his understanding that clinicians in the community-based clinician are earning salaries $20,000 below state employees doing similar work.

Heidi Hall, CFO and Mary Moulton, Executive Director, of Washington County Mental Health Services testified that they support including DA/SSAs into the system. Mary Moulton explained that for 10 years the Administration has not put in a request for a rate increase - we are level funded year after year. No Administration has put forth a rate increase in the budget presented to you for DAs/SSAs in at least 10 years, it's been the Vermont Legislature that provides increases; the most recent being three years ago. ADAP rates have had only two increases in the past decade (2013 & 2016). As a result of payment reform, value-based bundles were established in 2019 but have not increased in capacity or rates; therefore, we have increasing demands without resources to address it. Green Mountain Care Board is currently creating a review process for our budgets but cannot implement rate increases. Mary spoke about wait lists and staff vacancies to show how stressed the system of care is. she explained that fully funding community-based services will reduce having people use higher levels of care.

She shared the statutory language passed in 2017 which did not achieve the legislative intent of having an annual review and increases in rates.

Representative Rosenquist asked if this bill should be referenced in the new bill. Representative Brumsted expressed shock and concern about the waitlists and asked about how the rates impact that. Heidi agreed the rates reduce the ability to offer adequate salaries, additionally the funding is capped limiting the number of people who can be served to the 2019 level in mental health. Representative McFaun established that we need a rate and cap increase to meet the need. He wants to ensure that the existing statutory language will be followed, directing the Secretary of Human Services to adjust the rates. Representative Wood said the Global Commitment waiver does have a cap, so the cap is both a federal and state issue.

Nissa James, Health Care Director DVHA, explained that DVHA does want a reliable and predictable process for determining rates. Some rates do not have an established methodology. They also want to efficiently allocate public funds. Professionalizing reimbursement methodology includes aligning with other payer methodologies. DVHA has been working with home health and hospice to professionalize

methodologies and update them on a regular basis. The next providers to go through this process will be the assisted community care and enhanced residential care services in late 2021. DVHA requests that H.153 be explicit which services should be prioritized for payment review.

Angela Smith-Dieng Director of Adult Services at DAIL said they are in support of the intent of the legislation to develop and align methodologies consistent with other payers (where possible) and a predictable schedule for the rate increases. She sees rate setting is one part of payment reform and noted that DAIL does not have expertise to set rates; DVHA drives this process. The definition of home and community-based services in the bill should be clarified. They would like DS excluded because there is already work being done on DS payment reform that is addressing payment methodology. Representative Pugh and Representative Wood emphasized the importance of adequacy of rates. Smith-Dieng said DAIL does want adequacy of payments but is not sure that rate setting achieves that goal based on what they know from the nursing homes.

Laura Pelosi spoke on behalf of nursing homes and residential care homes. She is pleased that assisted community care and enhanced residential care are now having their rates reviewed. She shared that they have not had predictable and necessary rate increases. Jill Olson testified in favor of the bill and explained how home health agencies want predictable and reliable rates. A study found that HHAs are losing 27% on the Choices for Care program because they must provide competitive compensation rates. They have a 25% vacancy rate for personal care.

Susan Aronoff testified that the Developmental Disabilities Council supports H.153 due to the high vacancy and turnover of staff caring for people with developmental and intellectual disabilities. Terry Holden talked about the experience of her son through COVID. She spoke about how 15 different people have provided personal care for her son and how she has to train each one. She said the work is hard and the personal care staff don't get benefits. Many of the people have to be trained for medical needs such as diabetes, epilepsy, etc. Susan acknowledged that there has been a rate study for DS as part of the payment reform process, but that providers are concerned about the result of that study. Susan spoke about the need for rate increases for shared living providers, too.

Representative Wood made it clear that mental health and developmental disabilities will be added to the bill. She noted that the mental health payment reform did not result in any ongoing rate review and COLAs to keep pace with cost increases.

Sarah Clark CFO, AHS, testified on the global commitment cap. Longstanding CMS policy requires that Medicaid Section 1115(a) demonstrations be budget neutral to the federal government; meaning that federal Medicaid expenditures for a state cannot exceed what would have occurred without the waiver. The Committee learned that the state appropriation also limits expenditures. Furthermore, the enrollment in the Medicaid program impacts expenditures as well. She explained that there is also an investment cap within the larger cap. She explained that there is a specific DMH budget with allotments for each DA/SSA which they must live within.

Representative Wood used the language in the 2017 statute for DA/SSAs and wants to apply it to a broader array of providers and require rulemaking to improve implementation of the statute. Here is the language.

> § 911. PAYMENT RATES FOR PROVIDERS OF HOME- AND 3 COMMUNITY-BASED SERVICES
> (a) The Secretary of Human Services shall establish payment rates for providers of home- and community-based services that are reasonable and adequate to achieve the required outcomes for the populations

they serve. When establishing payment rates for home- and community-based service providers, the Secretary shall adjust the rates to take into account factors that include:
(1) the reasonable cost of any governmental mandate that has been enacted, adopted, or imposed by any State or federal authority; and
(2) a cost adjustment factor to reflect changes in reasonable costs of goods to and services of providers of home- and community-based services, including those attributed to inflation and labor market dynamics.
(b) When establishing rates of payment for providers of home- and community-based services, the Secretary may consider geographic differences in wages, benefits, housing, and real estate costs in each region of the State.
(c) The Secretary shall adopt rules setting forth the methodology for establishing payment rates for providers of home- and community-based services in accordance with this section. The rules shall include a process for determining an annual inflationary rate adjustment, shall set forth a predictable timeline for redetermination of base rates, and shall use Vermont labor market rates and Vermont costs of operation.

Sec. 3. 18 V.S.A. § 8914 is amended to read:
§ 8914. RATES OF PAYMENTS TO DESIGNATED AND SPECIALIZED 5 SERVICE AGENCIES * * *
(c) The Secretary shall adopt rules setting forth the methodology for establishing payment rates for services provided by designated and specialized service agencies to individuals with mental conditions, individuals with substance use disorders, and individuals with developmental or intellectual disabilities in accordance with this section. The rules shall include a process for determining an annual inflationary rate adjustment, shall set forth a predictable timeline for redetermination of base rates, and shall use Vermont labor market rates and Vermont costs of operation.

Sec. 4. HOME- AND COMMUNITY-BASED SERVICE PROVIDER RATE STUDY; REPORT
(a) The Department of Vermont Health Access, in collaboration with the Departments of Disabilities, Aging, and Independent Living, of Health, and of Mental Health, shall conduct a rate study of the Medicaid reimbursement rates paid to providers of home- and community-based services, as defined in 33 21 V.S.A. § 900, and providers of substance use disorder treatment services.
including their adequacy and the methodologies underlying the rates. As part of the rate study, the Department of Vermont Health Access shall:
(1) delineate a reasonable and predictable schedule for Medicaid rates and rate updates;
(2) identify ways to align Medicaid reimbursement methodologies and rates for providers of home- and community-based services with those of other payers, to the extent such other methodologies and rates exist; and
(3) determine ways to limit the number of methodological exceptions.
(b) On or before January 15, 2022, the Department of Vermont Health Access, in collaboration with the Departments of Disabilities, Aging, and Independent Living, of Health, and of Mental Health, shall report the results of the rate study conducted pursuant to this section and their findings and recommendations to the House Committees on Human Services and on Appropriations, the Senate Committees on Health and Welfare and on Appropriations, and the Secretary of Human Services. The rules must be in effect by July 20, 2022.

There will be a fiscal note on the costs for DVHA to do the financial analysis in 2022 estimated at $200,000. Representative Wood suggested that they prioritize this group of services in their existing contract with Burns and Associates. Nissa James of DVHA said as the scope of services has increased, they will need until July 1, 2022 to complete an analysis.

The bill was approved 11-0. The House Appropriations Committee will review it due to the fiscal implications. Representative Wood pointed out that the legislation could impact 10,000s of Vermonters and has been decades in coming.

Senate Appropriations Committee Reviews H.315 – One-time Bill
Senator Kitchel reviewed the mental health sections of H.315. She wants to make one-time investments in section 4 that will assist designated and specialized service agencies and has heard from agencies that the grants should be used for long term benefit to address funding needs of structures. As written, it will not improve the fiscal status of agencies. Senator Kitchel plans to rewrite it. Senator Sears is concerned that the one-time funds could lead to ongoing expenses if it is used for housing. Senator Kitchel and Senator Sears do not want to expand services without ongoing expectation of funding.

Senator Kitchel is concerned about the bill's language calling for each agency to hire one case manager and would like more information on the proposal.

For the training funds there were questions about what the $150,000 would do and for which sectors of the health care workforce. What would it buy, how would it be delivered and for who?

Senate Health and Welfare Reviews One-time Bill H.315
Stephanie Barrett of Joint Fiscal Office reviewed the bill and said that the Senate Appropriations Committee plans to broaden the language on housing. The Senate Health and Welfare Committee will be giving recommendations to the Senate Appropriations Committee. The Senate Appropriations Committee plans to finalize H.315 by March 19th.

Frank Reed, Director of Mental Health Services and Cheryle Wilcox, Interagency Planning Director for DMH reviewed the sections. They appreciate that funds are awarded to DMH. Emergency outreach funds would be appropriately expended. Frank said there is a clear need for housing supports. They would recommend a broader intent, and would consult with AHS, DAIL, DAs and peer organizations. They would work on developing priorities. DMH would like to have funds to support peer organizations to support people to access housing. They would also be helpful for transition age youth. The timing for the case management will work well given that the FEMA and SAMHSA grants are phasing down. DMH has partnered with Vermont Care Partners on COVID Support VT who has had 3 clinicians housed at VT 211. It would be a great transition to have regionalized support people as that initiative phases out. The case managers could also do outreach to the homeless and people in hotels. Cheryle made a commitment to work collaboratively with DAIL to ensure DS-only agencies are not left out. DMH believes there is expertise to do training and that expertise in the provider network and at DMH.

Julie Tessler reviewed the request of Vermont Care Partners for one-time funds. Vermont Care Partners original request for one-time/short-term Investments to respond to surge in demand due to COVID was:

- Short-term funding for motel/hotel outreach through non-categorical case management. The cost would be $85,000 per case manager X 10 Designated Agencies for a total of $850,000.

- Training on trauma-informed care and wellness support for DA/SSA staff. The cost would be $150,000 with some shared training across the system of care and agencies investing in wellness supports for staff.

- Invest in make existing housing and community-based service facilities more accessible, safe, and ADA compliant, or to expand capacity. For years agencies have deferred capital investments in favor of sustaining services leading to unmet capital needs. If a capital Investments are possible, we would benefit by these investments:
  a. New Facilities $8.8 million
     - Housing for homeless, elders, adults with mental health and I/DD, crisis beds, office space

b. Renovations, Upgrades $7 million
   - Address safety risks, insulation, ADA and HIPPA compliance, air filtration systems, elevators/ chair lifts

c. Repairs and Maintenance $1 million
   - Replace roofs, windows, doors, flooring, carpeting, ramps, boilers, kitchens

- Address one-time COVID expenses not covered by federal resources – HVAC systems, equipment, and testing.

These are the recommendations made by Vermont Care Partners:

- Section 4. $4 million general funds for Housing Supports in community settings; The grants shall be awarded to organizations that demonstrate the greatest ability to respond immediately to the need for housing supports and shall be for projects that will not require additional State funds for operating costs in future years or that can redirect current expenditures, or both. To the greatest extent possible, grants shall be awarded for projects in underserved areas of the State. At least one grant shall be awarded to a peer-run or peer-directed housing organization. Priority criteria: (1) create movement within the current system of care, such as those that would move individuals out of hospitals and other restrictive settings and back to a community setting. (2) focus on equity and on providing patient-centered care; and (3) employ or build on successful, evidence-based models of supportive housing.
  Recommendation
  It would be appropriate for the funds to be appropriated to **AHS** who would then, in consultation with Vermont Care Partners and peer run organizations, allocate the funds to DA/SSAs and peer-led organizations to address **developmental** and mental health service needs. Also, please consider using this simplified language: *Grants may be used to make existing housing and community-based service facilities more accessible, safe, and ADA compliant, or to expand capacity.*

- Section 5. $850,000 general funds to provide case management staff at the Designated and Specialized Service Agencies. Each DA and SSA needs to hire an additional case manager for one year to provide case management services to Vermonters whose lives have been upended by the COVID-19 pandemic and who need of urgent supports right now.
  Recommendation
  Raise the appropriation to $1.02 million to cover 10 designated and 2 specialized service agencies or if the appropriation remains at $850,000 then only allocate the funds to the 10 designated agencies to fully fund each case management position for 1 year.

- Section 6. $150,000 general funds for training and wellness supports for front line health care workers to help them meet Vermonters' current mental health needs, such as training for emergency department personnel responding to an increased demand for crisis services as a result of the COVID-19 pandemic and training on trauma-informed and trauma-specific care for mental health professionals responding to the surge in mental health treatment needs. The staff would also benefit from wellness supports as they continue to care for people in crisis while experiencing their own stress, anxiety, and trauma as a result of the pandemic.
  Recommendation
  Clarify this language. Who will provide the training and to which health personnel? Vermont Care Partners would be glad to provide training for frontline health workers on trauma-informed and trauma-specific care through our webinar series at minimal cost. Specify a dollar- amount for wellness supports for DA/SSA staff.

Senator Cummings wanted to know how much we would need to raise to address the inequities in salaries. Senator Hardy said investments in facilities is the perfect one-time investment and wants to invest more.

Hilary Melton asked that Pathways receive funding for expansion statewide.

POLICY LEGISLATION

House Health Care Committee Listens to Proposal for New Expanded Secure Residential Facility
The House Health Care Committee will provide comments to the House Corrections and Institutions Committee on the $11 million capital investment to build a new secure residential facility to replace the Middlesex Therapeutic Residential Facility. The funding to build the facility would be included in the capital budget but operational funding would need to come from ongoing appropriations.

Commissioner Sarah Squirrel and Deputy Commissioner Mourning Fox began by presenting the Department of Mental Health proposal to replace and expand the secure residential residence that is currently housed in a temporary facility in Middlesex. They were accompanied by Dr. Alisson Richards, Medical Director, Vermont Psychiatric Care Hospital, Dr. Kevin Huckshorn, and Dr. Janice Lebel. The Commissioner reviewed the history of the facility which was intended to be temporary and has outlasted its lifespan. She reviewed that all residents need the secure level of care provided by the program. DMH sees the program as an important step-down capacity from level 1 beds needed in the system of care and important to enable flow through the system of care.

- The secure recovery residence serves the highest acuity population of individuals who are ready to discharge – 95% of referrals come from Level 1 units from across the state;
- Replacing the current residence and expanding capacity will greatly improve the movement of patients through our system; supporting timely discharge and inpatient bed availability in the system of care, relieving pressure through-out the system;
- Without it we will be doing a disservice to those individuals who are ready to step down from hospital level of care, need transitional support and require a safe and secure setting as they work towards recovery;
- Collaboration & partnership are key tenets of advancing this urgent and important capacity in our system of care

She spoke about the level of safety risk and the ability to provide care to forensic patients. Based on stakeholder feedback, DMH is withdrawing the plan to use seclusion and restraint.

Analysis of Residential Bed needs indicates that at any given time 7 – 10 individuals could step down to a physically secure recovery residence. The proposal is consistent with Vermont's 10-year vision to decrease inpatient bed capacity.

Dr. Alisson Richards, Medical Director, Vermont Psychiatric Care Hospital spoke about the challenges of the population served and the challenge of the current facility. She described a few people there who cannot be served by designated agencies due to history and risk of violence and concerns about safety in the community.

Dr. Kevin Huckshorn who has experience in several states said without secure residential, people will be caught in inpatient beds. These people are vulnerable and deserve to have the supports they need. Dr. Janice Lebel said this proposal is state-of-the-art trauma-responsive and evidence-based approach of providing a continuum of care. She appreciates how service users and the advocacy community have been involved.

The overall operating costs will be reduced from the currently proposed $9.1 million annually due to eliminating seclusion and restraint procedures.

Kate Lamphere, LICSW, Director of Adult Services, Health Care and Rehabilitation Services testified on behalf of Vermont Care Partners. She said we oppose expansion from 7 to 16 beds and that we encourage that we have a fully functioning system in place to see the impacts on the system of care before more beds are built. She was clear that we are in support of replacement of the existing facility. We would support expansion only if it is shown to be needed. Kate recommended that if the facility is not expanded that the resource be directed to more adequately fund DA/SSAs. Concern was expressed that community services are being done by inexperienced staff. Once staff build the skills needed they move on, they can't afford to stay at the agency. Kate is concerned that services are harmful to people with the highest needs. She testified that there is room for further residential options to be developed including: peer respite, group homes, intensive residential programs, and crisis stabilization program, as well as safe supportive housing. Investment in community will keep people out of secure and inpatient care. The Committee was urged to invest in less harmful community-based services, community education, tolerance, and against stigma. If after all of that we still need expansion in secure residential, then we will support it. She encouraged the committee to listen carefully to the people who have been psychiatrically labeled.

Ward Nial spoke on his own behalf as an independent advocate. He supports investment in community-based services and opposes the use of involuntary procedures. He said he always hears that something else has to be done first before the community investments.

Malaika Puffer a resident of Windham and a manager and leader at HCRS has been in the CRT program and experienced involuntary procedures and hospitalizations. She has advocated for individuals in the emergency departments and hospital; and has friends who have resided at the secure residential facility. She agrees with DMH that it needs to be used and would like IMDs to be phased down. She expressed concern about not hearing about the decision not to use involuntary procedures at stakeholder meetings. She opposes expansion of the facility and questions the need for locked doors and fenced in yard. From her perspective, the space looks just like a hospital. "You can't lock people in a cage and call it trauma-informed."

Malaika asked about alternatives considered to the current facility. "As an advocate I have not been invited to consider alternatives. It is possible to serve people in programs like MyPad by investing in supportive housing." She believes that people are continuing to be served in more restrictive settings because the state is continuing to invest in these settings. She does not agree that this facility will reduce emergency department wait times. People end up there because they don't have another place to go. The crisis teams have told her to go to ED to be screened. The reality is that many people are experiencing unmet needs in the community. Very often people need housing and connections to people. She would like DMH to invest in community solutions. The 2030 Vision calls for creating places for people to go as an alternative to emergency departments. That would reduce wait times and back-ups in emergency departments. She would like to go back to the drawing board to see what the people in Middlesex need. They should bring together stakeholders to determine the best solutions.

Karim Chapman, Executive Director, Vermont Psychiatric Survivors, testified that "it should not hurt to help". Community programs should be able to have resources to enable people not to have to go to emergency rooms. VPS does not support the expansion of the facility and does not want involuntary procedures. He feels that stakeholders have been brought to the table late in the game. The evidence is there that peer support works at reducing the need for hospital settings. He does want to see the current facility replaced.

Representative Goldman asked about the situation with closed beds. Commissioner Sarah Squirrell said there are many closed beds in the system of care. Even on the community side capacity is down due to workforce challenges. As we get through the pandemic, we think capacity will increase and that DMH will continue to assess conditions on the ground as the 10-bed unit at the Windham Center and the 12-beds unit of BR come back online. Pre-COVID we were experiencing back-up in emergency departments. After COVID we may experience increased demand. The step-down at secure residential is a different level of care. The Commissioner acknowledged that there are 53 beds closed in the system of care and there will be a total of 65 more beds when the 12-bed unit at that Brattleboro Retreat opens.

Representative Peterson asked, given that we need more capacity what are the options? Malaika responded that we could use more MyPad and intensive residential services and move the secure residential beds into Vermont Psychiatric Care Hospital.

Shea Witzberger, of Dummerston, is the co-facilitator of the Brattleboro community safety review project. The project focuses on policing and mental health. They listened to over 250 citizens. Overwhelming, psychiatrically labeled individuals said locked wards are impacting their safety. Many said the current system of mental health care is punitive. The existing facilities were described as places of torture and they felt there is little accountability for the harm that is happening. People felt traumatized by locked wards. They feel they can't use a designated agency due to the threat of hospitalization. She believes that continued investment in this part of the mental health system is an injustice. She recommends a peer-led mobile crisis, 24/7 drop in space for people in crisis. They would like respite and training of community members to support people in psychiatric crisis. The flow of the people into and out of the system is real, but more locked beds is not the answer. People are concerned about patient treatment and trauma. She thinks DMH has been disingenuous. DMH has not enabled people to bring reals concerns up. Locked spaces feel like criminalization and punitive treatment. This is particularly strongly felt by LGBTQ community. The investment would take resources away from what her community is asking for.

Calvin Moen of Brattleboro is a psychiatric survival and does support advocacy, training and workshops on intentional care support, psychiatric liberation, and alternatives to medication. He said the process about planning the facility has shut out the voices of the people who use services. He understands that the objections of the State Standing Committee have not be listened to by DMH. Even without involuntary procedures, the proposed facility is not a homelike, community-based facility. He wants different options. People are safest in their homes. He would like to see investments in housing. People continue to get hospitalized because their needs aren't met. They would rather use Alyssum which has a one-month wait. He believes we need alternatives to emergency rooms. He believes hospital emergency departments are a terrible place to be if you are in psychiatric crisis.

Emily Megas-Russell of Brattleboro is a social worker who has worked as the program director of Meadowview and oversaw the five residential facilities at HCRS. All facilities were unlocked and hands-off. She believes the programs can be feared-based. She said we need to support being housed and staying housed. These programs enabled people to live in a homelike setting which is critical in honoring human rights. Still, she noted, it's a struggle to remain person-centered because the programs are still paternalistic and fear-based and can uphold stigma toward people who are psychiatrically labeled. She is opposed to the proposed facility because it would be detrimental to the human rights of the peoples and a great expense to the state. Many people are successful in unlocked environments. She would like to look at approaches that will reduce violence. She believes that if the building is built, DMH will fill it. Alternatives abound at all levels of care. DMH should align itself with actual and

expressed needs of those with lived experience. She said that some people served in the intensive residential felt they had no other options. The programs must help people become part of their communities.

Eva Westheimer, Programs and Volunteer Coordinator, Out in the Open, which is a regional and statewide organization for rural LBGTQ people to have power and visibility. They continue to oppose the proposed facility. They would like alternatives that don't create long-term trauma and harm. The State has the ability to create alternatives that should be developed by people with lived experience peer-respite and community alternatives.

Devon Green, Vice President of Government Relations, Vermont Association of Hospitals and Health Systems testified that more resources should be distributed in the care continuum. We are in a unique position because there are more funds are available from the federal relief package for the continuum. One project they support is an alternative to emergency departments. Emergency Departments are not a great place for people to be when they are in a mental health crisis. Her understanding is that the secure residential is for people who community facilities are not accepting for services. There must be a resource for people who are stuck in the hospital because community agencies are not willing to serve them. She would agree that there should be more stepdown facilities. She said the waits in emergency departments is dangerous to the patients. People who wait for days at a time are more likely to have their conditions deteriorate. She does not see this as a zero-sum game.

Representative Anne Donahue said the barrier study showed a number of reasons why people are stuck in hospitals. There are people waiting for supervised living, nursing home placement, it was not clear to her that the study pointed out the need for residential care in secure residential. Representative Donahue asked if involuntary procedures are needed for this population. Devon, said some people may not need involuntary procedure, but still need secure residential.

Senate Judiciary Committee Finalizes S.3 on Competency to Stand Trial and Insanity Defense
David Scherr, Assistant Attorney General, Vermont Attorney General's Office and James Pepper the Deputy State's Attorney, Department of States Attorneys and Sheriffs worked with the Department of Mental Health on an amendment that all agreed to. The notice would be given only if the case has not been dismissed by the State's Attorney. This subdivision (2) shall apply when a person is committed to the care and custody of the Commissioner of Mental Health under this section after having been found: (i) not guilty by reason of insanity; or (ii) incompetent to stand trial, provided that the person's criminal case has not been dismissed.

Matthew Valerio, Defender General, Vermont Defender General's Office, wanted to make sure that people are not brought back due to minor violations of an order of non-hospitalization. Vermont Care Partners provided written support for this position.

There will be notification on release or discharge of the individual only if the charges have not been dismissed. The department notifies the State's Attorney and the State's Attorney notifies the victim. If a person doesn't comply with treatment the Commissioner of Mental health must notify the State's Attorney or the Attorney General if they prosecuted the case. Here is the language approved by the Committee.

> Notwithstanding the provisions of subsection (b) of this section, at least 10 days prior to the proposed discharge of any person committed under this section, the Commissioner of Mental Health shall give notice of the discharge to the committing court and State's Attorney of the county where the prosecution

originated. In all cases requiring a hearing prior to discharge of a person found incompetent to stand trial under section 4817 of this title, the hearing shall be conducted by the committing court issuing the order under that section. In all other cases, when the committing court orders a hearing under subsection (a) of this section or when, in the discretion of the Commissioner of Mental Health, a hearing should be held prior to the discharge, the hearing shall be held in the Family Division of the Superior Court to determine if the committed person is no longer a person in need of treatment or a patient in need of further treatment as set forth in subsection (a) of this section. Notice of the hearing shall be given to the Commissioner, the State's Attorney of the county where the prosecution originated, the committed person, and the person's attorney. Prior to the hearing, the State's Attorney may enter an appearance in the proceedings and may request examination of the patient by an independent psychiatrist, who may testify at the hearing. (2)(A) This subdivision (2) shall apply when a person is committed to the care and custody of the Commissioner of Mental Health under this section after having been found: (i) not guilty by reason of insanity; or (ii) incompetent to stand trial, provided that the person's criminal case has not been dismissed. (B)(i) When a person has been committed under this section, the Commissioner shall provide notice to the State's Attorney of the county where the prosecution originated or to the Office of the Attorney General if that office prosecuted the case: (I) at least 10 days prior to discharging the person from: (aa) the care and custody of the Commissioner; or (bb) commitment in a hospital or a secure residential recovery facility to the community on an order of non-hospitalization pursuant 2(II) at least 10 days prior to the expiration of a commitment order issued under this section if the Commissioner does not seek continued treatment; or(III) any time that the person absconds from the custody of the Commissioner. (ii) When the State's Attorney or Attorney General receives notice under subdivision (i) of this subdivision (B), the office shall provide notice of the action to any victim of the offense who has not opted out of receiving notice. (iii) As used in this subdivision (B), "victim" has the same meaning as in section 5301 of this title. (C) When a person has been committed under this section and is subject to a non-hospitalization order as a result of that commitment under 18 V.S.A. § 7618, the Commissioner shall provide notice to the committing court and to the State's Attorney of the county where the prosecution 16 originated, or to the Office of the Attorney General if that office prosecuted the case, if the Commissioner becomes aware that: (i) the person is not complying with the order; or (ii) the alternative treatment has not been adequate to meet the person's treatment needs.

The Department of Mental Health shall convene a forensics workgroup to include a representative of Vermont Care Partners.

(1) Identify any gaps in the current mental health and criminal justice system structure and opportunities to improve public safety and the coordination of treatment for individuals incompetent to stand trial or who are adjudicated not guilty by reason of insanity. The working group shall review competency restoration models used in other states and explore models used in other states that balance the treatment and public safety risks posed by individuals found not guilty by reason of insanity, such as Psychiatric Security Review Boards, including the Connecticut Psychiatric Security Review Board, 12 and guilty but mentally ill verdicts in criminal cases. (2) Evaluate various models for the establishment of a State-funded forensic treatment facility for individuals found incompetent to stand trial or who are adjudicated not guilty by reason of insanity. The evaluation shall address: (A) the need for a forensic treatment facility in Vermont; (B) the entity or entities most appropriate to operate a forensic treatment facility

The Committee approved the bill as amended.

House Health Care Committee Hears More Testimony on H.210 the Racial Disparities Bill

The Committee heard testimony from member of Vermont's Native American Community.

Judy Dow, Executive, Director, Gedakina, focused on culture humility a life-long process of self-reflection and explanation of one's beliefs. She would like more time for training for medical doctors and legislators. She noted that there are indigenous people living in Vermont who are not members of the

four recognized tribes in Vermont. They are using grants for families during the pandemic. They are supporting families to self-determine their path to health. These individuals are 3.5 times more likely to get COVID and even more likely to die from COVID compared to the general population. There is too little data and a lack of trust due to historically trauma.

Don Stevens, Chief, Nulhegan Band of the Coosuk-Abenaki Nation, only recently was able to purchase food cards for his people. He is working on improving access to vaccines and is focused on improving trust of his people in government and health care. Many of his people don't have affordable health insurance and have dealt with debt when they have used health care. There are significant health disparities and he spoke about SUD and MH in his own family. There is no one that can represent their communities in the public policy process. They don't have the type of jobs or wealth to actively participate in these public processes. There needs to be resources to enable native people to participate in these processes. He supports this bill.

Beverly Little Thunder, Member, Earth Walk Board and Standing Rock Lakota Tribe, spoke about how hard it is for native Americans in Vermont to afford and access health care. Without dental care many native Americans face challenges with eating. She spoke about the large number of natives Americans who are not part of the 4 recognized tribes. There is a large number of LGBTQ peoples who also are facing health disparities. Few indigenous midwives are available who are trained. Money is the big divider. She lost a son due to lack of access to adequate mental health care in another state. She sees a divided state of the haves and have-nots. She said many grants are written in a hierarchical way and the native community is culturally not hierarchical. The community needs support in how to apply for grants.

Andrea Brett, Chair, Racial Equity Advisory Panel and a member of the Abnaki does not have tribe affiliation. She works in the free clinic for under- and uninsured Vermonters. She said her family was impacted by the Vermont eugenics survey and knows that many native Vermonters do not openly identify as Abnaki. She knows that many Abnakis don't trust public safety, health care or the mental health system. Most people cannot afford plans on the health exchange. Medicaid is accessible to some but doesn't cover dental care. She agrees that 2-hours of training for health professionals is insufficient.

Wilda White, the founder of MadFreedom, a human and civil rights advocacy organization whose mission is to secure political power to end discrimination against people based on perceived mental state. Madfreedom is a member of the racial justice alliance and supports H.210. She became convinced of the value of the bill when she saw structural racism impact how vaccines have been distributed in Vermont. She believes this is a modest bill that sets up a foundation for eliminating health disparities. The State could better gain access to resources to address health disparities. She would like to see the definition of disability include mental and physical impairment that substantially limit one or more major life activities and people perceived as having a disability. The Commission of Health Equity is important because it will be populated by the people most effected. People with experience will be closer to the solution. She sees it as a modest bill, a first step. Wilda does not think expanding the Office of Racial Equity is the right approach to take this on; she believes it would further overburden that office unless additional resources are added, possibly a contractor. The Department of Health is concerned about adding a responsibility while coping with the COVID pandemic.

On Thursday afternoon the Committee worked through an updated draft of the bill based on the testimony heard. Legislative Counsel Katie McLinn explained that the new bill sets up a Health Equity Advisory Commission which will provide recommendations for development of a Health Equity Office and will advise state agencies and the legislature on cultural competencies. The Health Equity Advisory Commission will promote health equity and eradicate health disparities among Vermonters, including

those who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities. They will also develop recommendations for improving cultural competency and antiracism in Vermont's health care system through initial training, continuing education requirements, and investments. The bill calls for increased data collection and analysis by state government, as well. The responsibilities would be added to the Office of Racial Equity on a transitional basis until the Office of Health Equity is established. The work will be done by a contractor under the supervision of the State Director of Racial Equity.

Representative Brian Cina, the lead sponsor of the bill, said he sees people being oppressed in the health care system and he sees the commission giving them the ability to have a voice. Representative Anne Donahue spoke elegantly about how she appreciates the bill being inclusive of people with disabilities and the decision to have the advisory commission lead the formation of the office of health equity as the people with lived experience and who are affected by the disparities. Representative Bill Lippert also spoke about his experience with health disparities as a member of the LGBTQ community. He said, "This bill will not end the disparities but sets in motion, hopefully, a structure and set of voices to speak to and guide us further in ending health disparities."

Vote: 9-1-1 – Representative Peterson voted no. Representative Cina thanked the Vermont Racial Justice Alliance for their work in creating the bill.

House Health Care Committee Passes Bill on Interstate Practice of Telehealth

On March 11, House Health Care reviewed H104, "an act relating to considerations in facilitating the interstate practice of health care professionals using telehealth." This bill would establish a Facilitation of Interstate Practice Using Telehealth Working Group, which would be chaired and convened by the Director of Office of Professional Regulation, including representatives from health care professional organizations, insurers, and other stakeholders, and would consider:

(1)impacts and ethical considerations related to patient care and continuity of care;
(2) whether to limit to health care professionals with preexisting patient relationships;
(3) impacts on State regulatory oversight and enforcement, including the fiscal impacts;
(4) effects on prescribing;
(5) differences between the various states and U.S. territories in scopes of practice, qualifications, regulation, and enforcement;
(6) different policy options for facilitating interstate practice, including the potential for reciprocity with health care professionals licensed in Vermont;
(7) whether to explore the international practice of health care professionals using telehealth; and
(8) other issues relevant to facilitating the interstate practice of health care professionals.

The Working Group would be charged with issuing a report by December 15, 2021. This is a change from an original bill that the committee considered, which focused on licensed clinical mental health counselors only being authorized to practice across state lines. Based on input from OPR, the committee decided to pull back and consider interstate practice via telehealth more broadly in healthcare. The bill passed out of committee and will be going before the full House for consideration.

Senate Addresses Regulatory Flexibilities

On March 9, Senate Health and Welfare reviewed its bill on regulatory flexibilities, S117, and voted it out of committee. The bill extends to March 31, 2022 many of the provisions of 2020 Acts and Resolves

Numbers 91 and 140 allowing for health care-related regulatory flexibility during and immediately following the COVID-19 pandemic. One exception is that the ability to waive the requirement for informed consent will not be extended through March 31, 2022, but rather 60 days after the end of the declared State of Emergency.

Regarding audio-only health care, the bill requires that insurers cover this service. It authorizes the Department of Financial Regulation [DFR] to determine reimbursement rates for audio-only care in consultation with stakeholders. This week, the committee added this language about its intent: "In determining the reimbursement amounts, the Department shall seek to find a reasonable balance between the costs to patients and the health care system and reimbursement amounts that do not discourage health care providers from delivering medically necessary, clinically appropriate health care services by audio-only telephone." Senators Hardy and Lyons wanted to ensure that rates were not set so low as to dis-incentivize the use of audio-only care. In the bill, DFR is given the authority to set different rates based on type of service and to modify the rates each year. DFR is required to provide a legislative report on the use, cost, and efficacy of audio-only after standardized data from calendar year 2022 has been collected and analyzed. The bill was unanimously passed out of committee and is before the full Senate for consideration.

House General, Housing and Military Affairs Considers Eugenics Apology and Next Steps to Address It

House General, Housing and Military Affairs heard testimony on **JRH2** - a Joint Resolution sincerely apologizing and expressing sorrow and regret to all individual Vermonters and their families and descendants who were harmed as a result of State-sanctioned eugenics policies and practices and **H.96** - An act relating to creating the Truth and Reconciliation Commission Development Task Force.

Representative Anne Donohue testified on JRH2, setting the historic context of the racial, ethnic, and ableist bias that led to eugenics policies in Vermont, which encapsulated a strong element of cost-cutting to reduce the number of people in institutions through forced sterilization. She spoke about the long-term effects of the 1920's eugenics policies and how even today there continues to be implicit biases that result in what is called "diagnostic overshadowing" which causes health care providers and others to treat people with mental illness or disabilities, member of the BIPOC community, etc., differently, creating a system of lesser care for certain populations. She connected these issues to the need for H. 210, the health equity bill which addresses disparities in health care for various populations. The committee expects to review an updated draft of the bill next week.

H.96 – Amanda Garces of the Human Rights Commission (HRC) spoke about transformative justice, making sure the Task Force represents the groups that it needs to, and respecting that various groups will have different perspectives on "truth" and "reconciliation". She made these points to the committee:

- Do not get hung up on a perfect product but to devote energy to creating a process for groups to decide what reconciliation/remediation is appropriate.
- an apology should not be singular, it should always reference a next step

Representative Killacky wondered if the process shouldn't be a typical legislative summer study but rather a hybrid model including the Human Rights Commission and Xusanna Davis' office.

Representative8 Stevens asked if it would be helpful for his committee to have more training from the HRC on implicit bias training to help them deal with the many bills they have relating to bias and equity. Amanda Garces offered to provide that training whenever the committee desired.

Upcoming Events

Information on Your Senators and Representatives

Follow this link to determine your legislators and access their contact information. Legislators are listed both by DA/SSA and by the Committee they serve on. Please note there are new legislators on committees that have purview over policy and funding for the Vermont Care Partners network. https://vermontcarepartners.org/wp-content/uploads/2021/02/2021-Legislative-Committees-by-DA-SSA.xlsx

Action Circles Calendar

Action Circles maintains a calendar of Legislative breakfasts and events. This information can be found at: https://www.action-circles.com/legislator-events/

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
- Legislators' email addresses 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.