VERMONT CARE PARTNERS

Supporting Vermonters to lead healthy and satisfying lives community by community

Legislative Update for April 14, 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 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

The new federal relief bill, ARPA, will bring a larger than anticipated infusion of funds to the State of Vermont of nearly $2.7 billion of which $1.3 billion is directed to state government. It may lead to adjustments in state appropriations, once there is greater clarity about allowable use and restrictions of the federal fund. Most of the funds must be expended by the end of 2024 and most likely will not be used for funding base appropriations which continue on an annual basis. The state revenue forecast for FY22 is uncertain given the dynamics of federal funds and delays in income tax filing day to May. It appears that there are abundant one-time funds.

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 for 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

H.315 the Quick One-time Bill Passes the Full Legislature

The House concurred with the Senate proposal of amendment to H.315 the Quick One-time Bill with further proposal of amendment. The $4 million for facility and housing investments for the developmental and mental health system, $850,000 for urgent care case managers at 10 designated agencies and $150,000 for health training and wellness supports for health and mental health workers stayed in place. The Bill was delivered to Governor Scott on April 12th for enactment into law.

POLICY LEGISLATION

Senate Health and Welfare Hears Proposal on Secure Residential

Commissioner Squirrell gave a quick history of the Middlesex secure residential facility and emphasized that it was only meant to be temporary. She explained that secure residential is a critical component in the continuum of care. Without adequate capacity for people stepping out of hospital level of care the flow through the system of care is impeded. She noted that 100% of referrals for secure residential care are from hospital level 1 care. The importance of the strong community-based system of care was highlighted. The Commissioner pointed out that Vermont makes a higher investment in community-based mental health care than other states, with 77% of public funds going to the community rather than inpatient care. New federal funds will be invested in the community mental health system to further strengthen it.

The current facility is at capacity all the time, the new facility will be able serve 16 individuals which data indicates is needed. She spoke about the decision not to use involuntary procedures as a response to stakeholder input.

Dr. Alison Richards spoke about the clinical needs of the people served in the secure residential residence. Deputy Commissioner Fox gave the Committee a tour of the proposed facility based on an artist's renderings. The goal is to give it a residential rather than an institutional feel. Fox said the program will empower the residents and will be trauma-informed with peer staff and oversight.

Dr. Kevin Huckshorn said the people who will use the services are very difficult to serve and used to be stuck in the state hospital. She said that with the proper services these individuals will be able to transition successfully back in the community. In her opinion, providing this level of care is critical. Dr. Janice LaBel said Vermont enjoys a reputation for excellence. She is concerned that we will have a "tsunami of need" due to the pandemic. The design of this facility and its programming will be essential to enabling flow through the system of care as the need increases.

Here is the link to the DMH PowerPoint:
https://legislature.vermont.gov/Documents/2022/WorkGroups/Senate%20Health%20and%20Welfare/Mental%20Health/W~Sarah%20Squirrell~Proposed%20Department%20of%20Mental%20Health%20Recovery%20Residence%20Presentation~4-6-2021.pdf

House Judiciary Committee Continues Testimony on S.3

Simha Ravven, MD, testified as the President of the Vermont Medical Society. She also serves as the Medical Director of the Howard Center. Additionally, she is a forensic psychiatrist who does criminal responsibility (insanity) and competency evaluations and provides clinical care to people who have histories of violence. Dr. Ravven appreciates the opportunity to improve services through the forensic working group proposed in the bill. She believes that people will be able to get robust specialized treatment and achieve improved community safety. Specific recommendations include:

1. Keep sanity and competency examinations separate. Competency determines the person's ability to participate in the criminal responsibility evaluation. She believes that Vermont could do more to work with people to restore competency.
2. The bill requires that when a person committed to an ONH is not in compliance the Commissioner is required to provide notice. She said it will be important for designated agencies to understand the specific reporting requirements. It should be delineated by the workgroup and enacted only after the workgroup completes its work. She added that the

notification requirement brings up a conflict in clinician's role to both support the client and police them. It might make sense to have this function addresses by a person who is not the clinician. Representative Rachelson wanted to know what that would look like.

3. It was recommended that the Forensic working group to have more time to complete their work, 6 – 12 months, with adequate funding to consult regional and national expertise.

Matt Valerio, Defender General, said it is difficult for people with mental illness to navigate the criminal justice system. Once you pass the bar of competency, you are treated like anyone else. The attorney looks at the facts and then determines which defense is appropriate. Insanity is a snapshot of the person's state of mind at the time of the crime. Competency determines if a person can participate in a trial. Insanity is a decision that should be made as contemporaneous to the event as possible. In his opinion competency is a low bar; It's hard to be found incompetent. He said juries don't tend to find people not guilty by reason of insanity. Matt does not want the State rather than the Court to choose the expert to determine competency.

Deputy Commissioner of Mental Health Mourning Fox testified that it's an important bill for a number of reasons. He addressed the insanity and competency evaluations and pointed out that competency can ebb and flow and said he wants to make sure that a person is competent to engage before the insanity evaluation is conducted. He concurred with Dr. Simha Ravven that many people can achieve restoration of competence with a competency restoration program, such as in other states. Separating the evaluations may delay the process, but it protects a person's rights and increases the likelihood they can participate in their defense and ability to better determine sanity. Karen Barber, General Counsel DMH, said that the national standard is to suspend sanity evaluation if the person is found to be incompetent. Fox said that the development of a forensic facility is critical to avoid having people receiving psychiatric hospitalization who don't need active treatment which is a violation of CMS requirements. He said it is important to develop a general fund financed forensic facility to meet their care needs.

Mourning Fox agreed with other people that the forensic working group should address notification when ONHs are violated and until they do, it should be struck from the current legislation. He also noted that if a person violates an ONH it does not mean that they meet the criteria for hospitalization which should be considered by the workgroup. He also asked for additional time of 6 – 12 months to do the studies required in the bill.

Honorable Brian Grearson, Chief Superior Judge, said once a person is found incompetent the focus becomes on the treatment needs and therefore it is important to call in Vermont Legal Aid and DMH.

Senate Health and Welfare Learns about All Payer Model Improvement Plan

Director of Health Care Reform for the Agency of Human Services Ena Backus reviewed the goals and priorities of the All Payer Model (APM) which is in performance year four. The performance improvement plan includes many different adjustments which CMS has accepted as reasonable next steps. Issues being addressed include the: scale targets; resetting risk requirements for hospitals; guidance for critical access hospital cost reporting; progress on achieving value-based payment (currently still tied back to fee-for-service for Medicare); encouraging CMI to allow FQHCs to achieve value-based payments. She pointed out the progress made in achieving scale target with the addition of the state employees into APM. Other progress included integrating Medicaid and private insurance claims into the Health Information Exchange; studying the efficacy of the care navigator platform; adding an incentive for Blueprint participation; increase screening for social determinants of health; and increasing real-time patient feedback. AHS and GMCB will use stakeholder forums for feedback; and are looking to increase prospective payment by OneCare and payers; improve incentives to achieve quality

of care and other required milestones; and identify cost-saving opportunities; increase use of data for improving care. Ena said the ACO should increase ability of providers to participate in prospective payment and achieve quality outcomes. See the PowerPoint at this link: https://legislature.vermont.gov/Documents/2022/WorkGroups/Senate%20Health%20and%20Welfare/Health%20Care/W~Ena%20Backus~Health%20Care%20Implementation%20Improvement%20Plan%20Presentation~4-8-2021.pdf

When asked if there is another model that could work better if the APM is not successful, Ena said we will not be able to determine our success with achieving APM goals until the last year of the agreement in 2022. At that point, if necessary, we will consider alternative approaches. Senator Hardy asked why we need so many different players leading the state system. Ena said we need a way for providers to work together to coordinate care which is why we have the ACO. Senator Hardy still wondered why we need an ACO to achieve that function.

Commissioner Robin Lunge, Sarah Kinsler and Alana Berube from the Green Mountain Care Board (GMCB) returned to discuss cost containment and value-based care which they see as critical to Vermont's health reform strategy. Critical questions they posed is "How should Vermont prioritize sustainability and reimbursement equity while balancing consumer affordability and access?" "How should Vermont define sustainability and reimbursement equity?" "How to prioritize where policy options have varied benefits and challenges for different provider types (e.g., hospitals vs. primary care providers; health systems vs. independent providers)?" "How should Vermont balance provider-led reform vs. mandatory regulation?" "How to support continued provider transformation and avoid change fatigue?"

Sarah Kinsler reviewed options to control costs. One option is to control health systems budgets with provider entity budgets with population-based payments. Another option is to adjust the ACO regulatory process to include state-set provider payment methodologies and amounts for attributed populations; or insurers could be required to population-based payments for providers. Another option is to regulate provider reimbursement to a growth rate and set unit costs of different health providers or types of services within a larger cap of cost growth. This approach could adjust relative payment levels to different providers within the health care sector.

Alena Berube, Sarah Kinsler and Robin Lunge explained that only a portion of health care spending, 2%, is in the fixed prospective payments and 14% are value-based in that the hospital hold risk on fee-for-service payments. Hospital budgets range from 0 - 24% in fixed prospective payments. Robin Lunge made it clear that mental health and substance abuse were left out of the APM growth cap to allow for greater growth in those services.

Senator Lyons expressed frustration that all these efforts are not resulting in reducing the growth of health care. Robin said we need to look at whether we are helping patients. There is a data lag. Robin said if the ACO is working correctly the patient shouldn't see it, but we do want to see quality improve and costs contained. She emphasized the need to have providers incentivized to achieve those improvements instead of trying to manage health care at a higher level. She has noted that COVID will make it harder to analyze if the APM is working. She is willing to come back and share data.

Senator Health and Welfare Considers Health Reform Options

Legislative Counsel Jen Carbee walked through S.132 as introduced. Senator Lyons, who is the lead sponsor, acknowledged that the Committee may want to trim down the proposed bill. The initial scope is quite expansive: (excerpted from the bill).

- Consolidate responsibility for health care innovation under the Director of Health Care Reform in the Agency of Human Services and to add new criteria to the certification requirements for accountable care organizations.
- Require accountable care organizations to collect, analyze, and report quality data to the Green Mountain Care Board to enable the Board to determine value-based payment amounts and the appropriate distribution of shared savings among the accountable care organization' participating health care providers.
- The ACO coordinates with the Blueprint's patient-centered medical homes and community health teams and acts as the link connecting patients with appropriate health care and social services, including those offered by designated agencies, specialized service agencies, parent-child centers, and schools.
- Require accountable care organizations to provide the Office of the Auditor of Accounts with access to their records to enable the Auditor to audit their financial statements, receipt and use of federal and State monies, and performance.
- Require the Green Mountain Care Board to review and approve proposed health care contracts and fee schedules between health plans and health care providers and would place certain conditions on the health care contracting process.
- Increase transparency in the purchase and lease of items of durable medical equipment and an incremental approach to requiring health insurance coverage for hearing aids.
- Require submission of reports to the General Assembly on health insurers' administrative expenses, inclusion of specialty care in the All-Payer ACO Model, accountable care organizations' care coordination efforts, and the likely impacts of requiring health insurance plans to offer at least two primary care visits per year without cost-sharing.

Joint Resolution Related to Racism as a Public Health Emergency by House Human Services
The House Human Services Committee reviewed and took testimony on Joint House Resolution 6. Because this resolution has policy implications it was referred to a committee for review, rather than other resolutions that do not and are simply put on the House Calendar for consideration by the full body all at once. The resolution includes extensive findings on the impact of racism on public health. At the end, the resolution commits the legislature "to the sustained and deep work of eradicating systemic racism throughout the State, actively fighting racist practices, and participating in the creation of more just and equitable systems, and be it further Resolved: That this legislative body commits to coordinating work and participating in ongoing action, grounded in science and data, to eliminate race-based health disparities and eradicate systemic racism,"

Mercedes Avila of the University of Vermont who is an expert on racial disparities in health testified that health disparities are preventable, and we can do things to prevent and eliminate them. COVID has brought attention to underlying health conditions that are a direct result of systemic, structural and institutionalized racism. She explained that we need to understand the underlying conditions, including the social determinants of health to understand how these disparities developed. We need strategic actions and investments to address these disparities. She shared data from the Vermont Department of Health on the disproportional prevalence of COVID among BIPOC communities. It was pointed out that BIPOC community, especially the indigenous community, is accessing vaccines at a rate lower than the white population. There are special clinics to address this disparity. She expressed a strong sense of urgency for having the resolution move forward. She suggested mandated training for all health providers on racism so that they are just and humane. She explained that race is a social structure, not a biological one.

Mark Hughes, Executive Director, the Vermont Racial Justice Alliance, testified about the work of the alliance including the resolution approved in Burlington and its impact on the collective work of local organizations including data collection. He supports the resolution because it addresses stark reality, and it makes a sustained and deep commitment to eradicate racism. He thinks it is an historic achievement.

House Human Services Committee Passes H.225

On April 6, the House Human Services Committee reviewed final language on H225, which decriminalizes the possession of 224mg or less of buprenorphine. For youth, the consequences of possession of buprenorphine will align with other substances: ages 15 and under will be "subject to delinquency proceedings family court, and youth ages 16-20 will receive a civil ticket and referred to the Youth Substance Safety Awareness Program and court diversion." Harm reduction advocates had testified this session and last session in favor of passing this bill to send a powerful message to people managing opiate withdrawal symptoms that possessing small amounts of buprenorphine is safer and preferable to heroin. At the conclusion of the brief discussion, Chair Ann Pugh concluded the vote by saying "Thank you all – this will save lives."

Health Commissioner Dr. Mark Levine submitted written testimony against H225, expressing concern that decriminalizing buprenorphine in a state with no waitlists for medication assisted treatment could incentivize diversion, disincentivize treatment, reduce the opportunity to refer people who need and want services when they are criminally apprehended, among other reasons.

On April 9th the full House of Representatives passed the Bill. It will now be taken up by the Senate.

House Education Hears Testimony on S.16, Creating a Taskforce on Exclusionary Discipline Reform

The House Education Committee heard testimony from a variety of stakeholders on S.16, which creates a taskforce on exclusionary discipline reform. The Taskforce is charged with collecting and analyzing data around disparities in the use of suspensions and expulsions based on race, disability, and socioeconomic status, and identifying and recommending best practices to reduce use of exclusionary discipline.

NFI Vermont Executive Director Chuck Myers provided background on NFI's five therapeutic schools that serve students with intensive behavioral needs. He stated that "although we are talking about behaviors in the school, it is important to include families and social context [when considering these behaviors] and the impact of intergenerational poverty." He noted that for some students, doing well in school presents an ethical dilemma because it may mean abandoning their families.

Kym Asam, Regional Director of Schools and Clinical Programming for NFI Vermont, testified on the values, principles, and practices that NFI uses to support students using a trauma-informed/responsive approach. This includes focusing on "relationship repair, not rules violation;" use of Positive Behavior Intervention and Support [PBIS] strategies and movement to support students in regulating their bodies. She spoke of the importance of reflective supervision practices and organizational wellness. In the rare instances where it is important for the student to leave the school community, NFI expedites a restorative practice to welcome the student back in. Asam recommended that the Taskforce:

- Include the expertise of those who work in therapeutic, day treatment schools.
- Think about systems change including intentional wellness opportunities for staff throughout their days (wellness is not an individual's responsibility alone. Organizations also have responsibility for promoting wellness).

- Provide necessary resources and coaching to ensure durability of change including trauma informed/responsive training, reflective practices and supervision and healthy forums in which to discharge adult distress.
- Consider how to integrate practices and resources to ensure there is alignment vs the all too common experience educators have of initiative fatigue.
- Reduce the tendency to engage in hierarchical dictates about what schools and staff must do and consider participatory decision-making. I.e., How do we want to be together vs this is how we are going to be together.

Amy Wheeler-Sutton, Training and Development Coordinator for the Vermont BEST Project, shared data on the efficacy of the PBIS framework by comparing out-of-school suspensions for "exemplar PBIS schools" with other PBIS schools and non-PBIS schools. She also encouraged the Taskforce to consider use of seclusion and restraint.

Jeff Goudreau from Peoples Academy spoke about the importance of school climate in reducing suspensions and expulsions.

Bernice Garnett and Lance Smith from the College of Education and Social Services at UVM provided a number of recommendations, including ensuring student experience data is collected along with quantifiable data. Garnett shared that in their research, black students observed that ""Whenever a black man is shot by the police, I come to school and all the teachers are acting like nothing happens. If they do mention it, all they say is, "oh that's so bad I don't want to think about it." I think you should not ignore it." The Committee plans to continue to take testimony on S.16 this week.

Information on Your Senators and Representative

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.