VERMONT CARE PARTNERS

Supporting Vermonters to lead healthy and satisfying lives community by community

Legislative Update for April 6, 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, American Rescue Plan Act (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 moved 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

Senate Health and Welfare Reviews House Budget Bill with Joint Fiscal Office's Stephanie Barrett
Stephanie Barrett explained that the House FY22 Bill uses $650 million of the $1.05 billion in ARPA of which $250 million is appropriated for the health and wellbeing of families. Spending parameters are set for 65% of the $1.05 billion leaving $400 million without parameters. Unallocated federal funds will be addressed during the remainder of this session and over the next few years. The budget bill sets up a

homeless transition work group to develop a plan to transition Vermonters out of hotels and sets aside $50 million to fund these services.

There is a 10% FMAP bump for one year to supplement, not supplant, services which could potentially add $20 million for appropriations. Stephanie said this will help smooth base increases into the budget such as the 2% rate increase for mental health, developmental services providers, Choices for Care, share living providers, and a $1 per day per person increase for adult community clinical services (ACCS) providers. Stephanie explained that ARPA includes an 85% Medicaid match for mobile crisis services for 3-years which could be used for the RMH mobile crisis pilot. Stephanie was clear that we are still waiting for federal guidance.

POLICY LEGISLATION

House Judiciary Committee Takes on S.3 on Competency and Insanity Defense
The House Judiciary Committee began deliberation on S.3 regarding competency to stand trial and insanity as a defense. Erik Fitzpatrick and Katie McLinn of Legislative Counsel walked the committee through the bill. Anne Donahue noted that the legal definition of mental illness in this statute includes a lot of conditions such as developmental disabilities and traumatic brain injury and as such she asked about the involvement of the Commissioner of DAIL in the sanity and competency process. The Committee will return to this question. The examination of sanity only occurs if a person is found competent to stand trial. If a person is found a danger to self or others they are committed to the custody of the Commissioner of Mental Health.

In current law there is no notification for the crime victim. The proposal in the bill is to create a system of victim notification. Victim notification applies if a defendant is committed to DMH after a finding of not guilty by reason of insanity; or incompetence to stand trial, provided that the person's criminal case has not been dismissed. 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, when the person is not complying with the order of non-hospitalization or the alternative treatment has not been adequate to meet the person's treatment needs. Representative Donahue questioned the assumption of a person being presumed a victim absent a trial.

Legislative Counsel Katie McLinn also reviewed the provisions in the bill calling for an evaluation of mental health services in the correctional system. "On or before November 1, 2021, the Departments of Corrections and of Mental Health shall jointly submit an inventory and evaluation of the mental health services provided by the entity with whom the Department of Corrections contracts for health care services to the House Committees on Corrections and Institutions, on Health Care, and on Judiciary and to the Senate Committees on Health and Welfare and on Judiciary. The evaluation shall include a comparison as to how the type, frequency, and timeliness of mental health services provided in a correctional setting differ from those services available in the community."

The Bill also establishes a forensic care working group convened by the Department of Mental Health. They are responsible to:

- Identify any gaps in the current mental health and criminal justice system 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.

- 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.
- 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.
- Consider the notification process by the DMH Commissioner to the prosecutor upon becoming aware that persons on orders of non-hospitalization are not complying with the order or that the alternative treatment is not adequate to meet the person's treatment needs.

Carol Kelly testified about her daughter's murder in Bennington. Two months earlier the person accused of the attack made a video on Facebook about his plan to commit murder. He had a long history of violence in the community and was released back to the community after stays in the state hospital. He had been found incompetent to stand trial. She felt that the system empowered him to continue to get more and more violent. She supports S.3 and the idea of a multidisciplinary review board similar to the one used in Connecticut. It is her belief that there is inconsistency in services across the non-profit mental health agencies and questioned if it might be better to have for-profit services.

Joanne Kortendic, whose sister was murdered in Burlington said the alleged attacker had bounced from the correctional system into the mental health system after the issue of competency kept coming up over a number of years. She would like to see more communication between the DMH and correctional systems and more focus in the mental health system on restoring competency so attackers can be tried. She would like more focus on bringing people to trial and strengthening the rights of victims.

Representative Anne B. Donahue agreed that the system requires a full-scale overhaul rather than focusing on pieces of it. There are no provisions for people with TBI or dementia. There are not enough tools in the statute for when a person violates an order of non-hospitalization. She would like expanded membership and a longer timeline for the forensics committee, as well as direction to the work group to look a different state models – not just the model used in one state.

A.J. Ruben, Supervising Attorney, Disability Rights Vermont which represents people with mental health disabilities and people who are victims of crime believes that Vermont should make improvements in representation of people with mental illness accused of crimes and wants the study of forensic capacity. The language on notification is unworkable from his perspective, because compliance with the treatment plan is not specified. He said that there are opportunities to enhance the mental health system and improve notice to victims which the study committee should take up and those sections should be deleted from the bill until that is done. He further recommended fully funding the community mental health system and the victims' advocacy system. He suggests giving people who are accused of a crime the opportunity to consent to notify victims.

Jack McCullough, Director of Mental Health Law Project, Vermont Legal Aid, represents people in all civil proceedings related to involuntary mental health care. He agreed with the concerns raised about the notification requirements and agreed that it should be left out of the bill; the working group should take up the issue up instead. He agreed with AJ that there isn't sufficient capacity in the community mental health system to adequately meet needs.

Wilda White of Mad Freedom, a Rights-based organization, said the Bill addresses complex policy issues that should be taken into careful consideration. She would like to see bill amended to allow the defendant to see their competency report as a matter of right. Wilda recommends that insanity and

competency exams continue to be done at the same time. She is concerned that there is a lack of consistency in forensic examinations allowing for the possibility of shopping for opinions.

Wilda is concerned about the notification when a person is not complying with the order of non-hospitalization (ONH) requiring DMH to give notice to the State's Attorney or Attorney General. HIPAA violation is not her primary concern, she said the US Constitution gives right of privacy in the 14th amendment. This notification as a clear violation she said because there is no clarity on why the information should be released. It further stigmatizes the person who should be presumed innocent if they have not been tried due to incompetence or determination insanity. On the forensic work group Wilda feels that just having one person with lived experienced is insufficient and there should be representation of persons who have direct experience with these issues. She does not think the Legislature should specify to review CT model of psychiatric review board, instead the language should speak to Vermont's values.

Kristin Chandler who leads the Team Two training program for law enforcement and designated agencies testified from the designated agency (DA) perspective for Vermont Care Partners. She noted that it will be helpful to have DMH at the hearings to inform the ONHs. She noted that there is not a comparable process for those found incompetent for other reasons.

The bill requires the DA to informs DMH if a person is not in compliance with the conditions. However, she noted that a person can be doing very well and not be in compliance. It is a liability for the DA if they don't report which sets up a revocation of the ONH but this may not be appropriate if a person has simply used alcohol or an illicit drug. DAs often work with people to support them to follow their ONH. For example, it can take time to find better housing or assist the person to improve compliance with their treatment plan. Kristin noted there are challenges in forcing someone to abide by conditions that don't meet their needs. The way the process works is that after a person is found not competent by the forensic psychiatrist DMH drafts the conditions with input from the mental health agency for the Court. Sometime a mental health agency has no opportunity to provide input. The bill calls for input from DMH and the mental health law project which Kristin says would be helpful. The person's treatment needs are not always evident if they are unknown to the system of care at the time the Court develops the ONH. She suggested that the workgroup should narrow down under which conditions a report should be made for noncompliance. She believes the study committee is going to need more time than is currently specified to accomplish its work.

Senate Health and Welfare Takes up H.153 on Rates for Medicaid Community Based Services

Representative Wood told the Senate Health and Welfare Committee that this bill "is short but mighty" because it could impact tens of thousands of Vermonters who have developmental and intellectual disabilities, who have brain injuries, older Vermonters and people with disabilities. It does not provide any required automatic rate increases but obligates AHS to review rates for home and community-based service providers including home health and DA/SSA. It instructs AHS to promulgate rules – "the legislative way of saying, we really mean it". She pointed out that these agencies provide services to the most vulnerable people in the State. The bill asks for the division of rate setting to determine reasonable rates and the information on how much it will cost to achieve those rates will be presented to the legislature. The ultimate goal is to enable the legislature to have the information on necessary rate adjustments and, if necessary, to go back to the Administration and ask them why rate increases were not made. Representative Wood reminded the committee that these organizations rely on Medicaid funding and three adult day agencies have recently closed their doors.

Jen Carbee walked the committee through bill. Senator Cummings said this is a lot of work for state agencies to do and questioned if all this work is necessary given that the Appropriations Committees already know we are inadequately funding these agencies. She added that the state pensions and salaries are eating up all of the revenues. She is hesitant to ask for this work if we are not going to fund it.

Nolan Langweil of the Joint Fiscal Office shared that a 1% increase in rates would be cost $4.5 million total funds and $2 million in general fund. The rate setting study would require contracts and positions. DVHA can ask for a budget adjustment if funding is not in the FY22 budget bill.

Corey Gustafson, Commissioner of DVHA and Nissa James, Health Care Director, DVHA testified on the bill. Corey said implementing value-based purchasing is a primary goal for DVHA. He said they are professionalizing reimbursement and want to be a reliable partner and use resources efficiently given finite funding. They are working to institute a regular process to update rates. This Bill is consistent with those goals. DVHA doesn't determine resources available. DHVA has done this work for home health services. There have been increases where DVHA has oversight. There are currently, nine payment reform processes underway and work with other Departments on payment methodologies. They will need funds to achieve this work and they are glad to do it with adequate resources. Nissa will be invited back to outline the resources and work necessary for DVHA to accomplish the work outlined in the bill.

Jill Olson, representing home heath and hospice acknowledged that it is a lot of work but important to have the structure to clarify just how much in trouble Choices for Care is. An analysis a few years ago found that the rates are 27% below costs for Choices for Care. At this time, 1 in 4 PCA positions are vacant.

The Committee will return to the bill next week with testimony from Vermont Care Partners.

Senate Health and Welfare Presents Report on Managing Health Expenditures

Act 159 directed the Green Mountain Care Board (GMCB) to study options for regulating provider reimbursements. They excluded DA/SSAs in their analysis, but the work has implications for the future of health reform in Vermont that could impact DA/SSAs.

GMCB Commissioner Robin Lunge explained that the Green Mountain Care Board has a mandate to work in collaboration with Department of Financial Regulation, DVHA, and the Director of Health Care Reform to "identify processes for improving provider sustainability and increasing equity in reimbursement amounts among providers. The Board's consideration include: (1) care settings; (2) value-based payment methodologies, such as capitation; (3) Medicare payment methodologies; (4) public and private reimbursement amounts; and (5) variations in payer mix among different types of providers." Robin explained that cost containment, reimbursement equity and sustainability must be balanced with consumer affordability and access.

Alena Berube, Director of Value Based Programs & ACO Regulation reviewed the options studied and noted that they could be layered and are not mutually exclusive. If multiple approaches are used it would add "complexity, expense and potential regulatory burden." The first option is to set a cap on health system budgets of providers or network of providers. She said it is generally done prospectively. Option 2 entails setting reimbursement parameters through a regulatory entity which sets limits on provider reimbursement but not for the health care system. Our hospital budget process would need to be upgraded to achieve this. Option 3 calls for Fee-For-Service Rate Setting in which a regulatory entity

sets reimbursement amounts. Medicare rates are often used as a foundation for this process. This option sets targets for cost but utilization is not managed so there is no set cap on expenditures.

Senate Health and Welfare Hears from Representative Lippert on Health Equity Bill

On April 1st the Chair of House Health Care Bill Lippert introduced the Health Equity Bill to the Senate Health and Welfare Committee. He believes that the bill is important for addressing health disparities and creating health equity for all Vermonters. The Bill was crafted by the Vermont Racial Alliance with Representative Brian Cina as the lead sponsor. The Bill sets up infrastructure to address health disparities and the findings and have extensive documentation about health disparities with links to source documents. The Bill addresses disparities related to race and ethnicity, LGBTQ community and people with disabilities. Rather than establish an office of health equity in the Department of Health as originally proposed, it sets up an advisory Commission with strong representation of affected communities with support from the office of racial equity. The Commission will advise on the development of the health equity office; address data needs and make recommendations for education of health care professionals. They will recommend whether the office of health equity is placed inside or outside of state government.

The Office of Racial Equity will support the advisory commission. Vermont's Director of Racial Equity Xusana Davis said she is disappointed that the office of health equity is not going to start immediately because people dealing with inequities have been waiting a long time. However, she sees a positive opportunity for the office to be set up based on the perspective of the Commission with feedback from the public.

House Education Committee Takes Testimony on School Exclusionary Discipline

Senator Cheryl Hooker provided an introduction of S.16 to the House Education Committee. The bill establishes a taskforce on school exclusionary discipline reform. She noted that young students who are expelled or suspended are ten times more likely to drop out of school and/or face incarceration. Certain ethnic groups and students with disabilities are disciplined at higher rates than their peers. This bill 1) establishes a taskforce to gather data and make recommendations; 2) bans exclusionary discipline for students under age eight.

The Committee discussed the concern that due to small school sizes, data on race can identify specific students. When asked why there should be a taskforce, Senator Hooker noted that the data in Vermont on whether disparities exist here is incomplete. The Committee discussed their concerns about expulsion at the pre-K level. Representative Sarita Austin noted that in her experience, expulsions/suspensions were rarely used as punishment and more as an opportunity for the team to come up with a plan that would work for the student. She noted the importance of including students in this planning.

Vermont Care Partners' Dillon Burns testified on behalf of the VCP network. She noted that network agencies serve over 10,000 Vermont students with intellectual and developmental disabilities and mental health needs, and strongly support the goals of the bill. The network has a lot of experience providing in-school services to support kids with behavior challenges to prevent expulsions and suspensions. The network supports past testimony that encouraged the taskforce to look at data that is already reported to the Agency of Education [AOE] and Department of Mental Health [DMH]. They appreciate the inclusion of therapeutic schools on the taskforce and request VCP membership as well.

Jay Nichols, Executive Director of the Vermont Superintendent's Association, testified that they were supportive of the purpose of the bill. "We need a clear picture of data in Vermont," he said, because they are not convinced that Vermont data aligns with national data. He advocated for the taskforce to include a special education director and expressed the concern that AOE may not have the personnel to participate meaningfully.

Jo-Ann Unruh, representing the Vermont Council of Special Education Administrators, noted that students of color and students with disabilities face both implicit and explicit bias. She noted that reporting is complicated by the issue of a "kid invited to go home for the rest of the day," which may not be counted as expulsion or suspension. Unruh noted that "student behavior is communication and belonging is the deepest need for children. Kids do not learn well if they don't feel like they belong." – She also noted that school staff need tools. She believes it is important to include a special education administrator on the taskforce. Restraint should be used with the most caution, given the possibility that a student has experienced trauma or sexual or physical abuse. Unruh advocated for: training school staff; supporting pre-school education; and using a Multi-Tiered System of Support [MTSS] framework.

Representative Brady spoke of the need for more staff training, particularly at the upper grades, and Representative Austin spoke of the need for students to have the skills to regulate their behavior. The Committee will continue to work on this bill.

Senate Health and Welfare heard testimony on H.104 on Interstate Telehealth

The Sente Health and Welfare Committee learned that H.104 would establish a time-limited workgroup, convened and chaired by the Executive Director of the Office of Professional Regulation (OPR), to focus on licensure issues associated with interstate and out-of-country telehealth. The workgroup would report back by December with recommendations to the Legislature. The genesis of the bill arose when licensed clinical mental health counselors in Vermont wanted to be able to continue treatment with clients in different states, but House Health Care realized that this was relevant to telehealth licensure practice issues for many different professions.

Jessa Barnard from the Vermont Medical Society testified that this bill focuses on "where and how you get licensed to serve someone in another state." OPR Executive Director Lauren Hibbert noted that the continuum of professions is vast, with some having stronger national networks and local associations, and some that are very loose. She is excited to work together to develop a statewide approach and framework for these issues governing all professions. She noted that DMH Commissioner Sarah Squirrell requested membership on the workgroup. Hibbert pledged to work with all professional associations to get input, whether or not they have a formal seat on the workgroup, through public meetings. Mike Fisher, Healthcare Advocate noted that there should be a consumer voice. He, Hibbert, and Barnard will work on how to establish that in the bill language.

House Human Services Takes Up Decriminalizing Small Amounts of Buprenorphine with H225

On April 1st and 2nd, House Human Services revisited H225, a bill that replaces criminal penalties with civil penalties for possession of 224 mg or less of Buprenorphine. Committee Chair Representative Pugh stated that this is a harm reduction bill, reminding the Committee that they supported it last year with an 11-0 vote but now there are two new committee members and she wants them to be informed.

Chittenden County State's attorney Sarah George testified that Buprenorphine blocks craving when a person is experiencing opiate withdrawal, and therefore reduces risk of overdose. She noted that when she stopped prosecuting for possession of small amounts, overdose fatalities dropped by 50% in a year. Noting that a harm reduction message is important for people to hear, she said "we *want* people to possess bupe" as opposed to heroin. George questioned whether people 21 and under need a different response. Replacing a criminal consequence with civil ticket leads to fines, which then can lead to loss of license, and further fines and fees. She supports diversion and treatment – not financial consequences.

In discussing why overdoses have risen so dramatically during COVID-19, George speculated that it could be because harm reduction tools (fentanyl strips, Narcan) are not as available. George noted that her office is still charging for large amounts, but she wants to emphasize that even if someone is arrested (and not eventually charged) the arrest itself is harmful. George answered Committee questions on how it works when a person gets a three-day supply in Emergency Departments, and then are referred to Safe Recovery, primary care, or other treatment.

Willa Farrell from the Attorney General's Office testified on court diversion for youth. Tamarack has the same structure as court diversion, but the focus is for mental health and substance use disorder: to keep youth supported in treatment. The Attorney General's office would like to prioritize access to treatment. The Committee discussed revising the language of the bill so that possession of Buprenorphine for young people has the same consequences as cannabis or any other drug. Representative Redmond shared her sense of urgency to pass this legislation. She noted that 13 women who have come out of incarceration have died due to overdoses.

Dr. Kim Blake from Safe Recovery testified on April 2nd. She explained the low barrier approach embraced by Howard Center's Safe Recovery. She noted that some people prefer to use buprenorphine off the street versus through a treatment program because of the requirements for counseling and groups associated with those programs. She shared that she asked several patients about whether teens use suboxone. Their response was "only if they need it" i.e. to manage withdrawal symptoms. Representative Rosenquist asked about whether patients can taper off medication assisted treatment, and Dr. Blake shared that this should be done with extreme caution. She shared a story about a treatment facility attended by her son, who died of an overdose, where the program did not offer medication assisted treatment for opiate addiction and in one year, almost half of the people in the program who did not use maintenance medication died. For most people who use opiates, they don't get a high from Buprenorphine at all.

Julea Larson, supervisor of Recovery Services from Turning Point in Bennington, testified that Chittenden and Bennington counties have doubled harm reduction efforts. She shared that her organization as well as Spoke clinicians are seeking out people in hotels and motels and offering instant access to medication-assisted treatment along the "802 Quits" model. "Almost everyone we talk to says if I didn't have to deal with withdrawal, I would stop." Some of the people she works with prefer to purchase suboxone off the street to avoid seeing people at a treatment site that they have a hard time saying "no" to. Some people who are coming out of incarceration need street suboxone as a bridge to treatment in the community.

The Committee plans to vote on this bill on Tuesday, April 6. Draft Bill Template (vermont.gov)

H. 329 - Amending the Prohibitions Against Discrimination Reviewed by House General Committee
Representative Christie, the lead sponsor of H.329 gave an overview to the House General, Housing and Military Affairs Committee. The Bill amends the prohibitions against discrimination in employment,

education, public accommodations, and housing to provide that harassment need not be severe and pervasive to constitute unlawful discrimination. It also would establish a uniform six-year statute of limitations for claims of discrimination in employment, public accommodations, and housing. If the bill becomes law an employee would not need to pursue an internal grievance process prior to filing a claim and would not be required to demonstrate that a comparable employee was treated differently to prove that discrimination occurred.

The current complication with the statute of limitations is that for personal injury the statute is 3 years, for financial injury, the statute of limitations is 6 years. This would move all claims of discrimination to a uniform 6-year statute of limitations. The rest of the bill relates to the definition of unlawful discrimination and the level of severity of harassment that constitutes a viable claim. Representative Christie testified that the impetus for the bill came from recurring issues seen by the Human Rights Commission in working with discrimination claims. The committee intends to take a more thorough walk-through of the bill at a later time.

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.