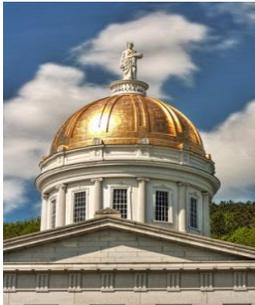




Supporting Vermonters to lead healthy and satisfying lives community by community

Legislative Update for May 4, 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

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

Full Senate Approves FY23 Budget Proposal

On April 30th the Senate approved the appropriations bill with significant amendments from the House Bill. It now goes to the House of Representatives for consideration. The House is not likely to approve the Senate version of the budget. A committee of conference will be convened to work through the differences and present a revised appropriations bill for full legislative approval. After the Legislature approves the bill, the Governor receives it and decides whether to approve it or veto it. This year a veto is a possibility, in which case the Legislature may try to override the veto with a 2/3rds majority in both chambers, or they may choose to make revisions and resubmit it. This may require the legislature to call a special session. The goal is to complete this legislative session by the 3rd week of May.

As noted in last week's update Vermont Care Partners is pleased that the Senate included a 3% Medicaid rate increase for designated and specialized service agency developmental and mental health services, as well as language that will release funds for loan repayment and tuition assistance to staff of the agencies who provide mental health and substance use disorder services.

POLICY LEGISLATION

Senate Health and Welfare Committee Approves S.120

After many days of testimony and deliberation the Senate Health and Welfare Committee approved S.120 on a vote of 5-0-0. Committee Chair Lyons said she is working on a path to bring the bill forward but acknowledged that the House is concerned about the lateness of the bill. It would be a heavy lift for them to accept the bill at this time. Funding for the taskforce on accessible and affordable healthcare as proposed in the bill was included in the Senate's version of the FY22 budget bill.

The Task Force would be composed of three members of the House and three members of the Senate and is tasked with exploring "opportunities to make health care, including prescription drugs, more affordable for Vermont residents and employers, including identifying potential opportunities to leverage federal flexibility and financing and to expand existing public health care programs. It would hold public hearings on health care affordability and would report to the full legislature by January 15, 2022 on "cost-effective ways to expand access to affordable health care for Vermonters without health insurance and those facing high health care costs and the various options available to implement these recommendations."

The bill also states "an accountable care organization shall collect and analyze clinical data regarding patients' age, health condition or conditions, health care received, and clinical outcomes in order to determine the quality of the care provided to its attributed patients, implement targeted quality improvement measures, and ensure proper care coordination and delivery across the continuum of care." The results are to be reported to the Green Mountain Board. Another requirement of the ACO is to provide a description of its initiatives to connect primary care practices with social service providers to the Senate Health and Welfare, and House Health Care Committees.

Bill Updates in House Health Care

On April 27, 2021, House Health Care reviewed the status of several bills. In H.104, which creates a "Facilitation of Interstate Practice Using Telehealth Workgroup" with legislative recommendations due in December, they noted that Senate Health and Welfare had added the DMH Commissioner or designee to the list of taskforce members. The proposed taskforce already includes members of healthcare professional organizations (such as VCP). They also had no concerns with Senate changes to H. 46, which now requires the State to collect information on Emergency Involuntary Procedures (EIPs) for voluntary patients. They also support the redrafted bill's change in the use of the terms "he or she" to "the patient."

Representative Anne Donahue shared that House Corrections and Institutions adopted House Health Care language on the Secure Residential proposal in the Capital Bill, H.438, wholesale. It specifies design of the secure residential facility, including dividing the dining area into two small rooms to reduce the scale to achieve a more homelike feel. Also in the Capital Bill, the Department of Mental Health (DMH) is directed to issue a request for information (RFI) from designated and specialized service agencies and peer-run agencies for developing and implementing unlocked community residences for transitional support for individuals discharged from inpatient psychiatric care or to prevent inpatient care. It

requires that the RFI be issued by August 1, 2021, with responses due by December 1, 2021. The Department of Mental Health wrote to the House Health Care Committee to ensure them that children and youth will be prioritized in the RFI. DMH will return to the House Health Care Committee this Tuesday to discuss immediate actions to address the crisis of children stuck in hospital emergency departments.

The committee also reviewed Senate changes to H.210, which creates a Health Equity Advisory Commission. It will return to the bill again when the Senate's work is complete.

Bill H.225 on Decriminalizing Small Amounts of Buprenorphine in the Senate for Consideration

On April 29, 2021, Senate Judiciary and Senate Health and Welfare held a joint hearing on H.225, which decriminalizes small amounts of Buprenorphine, also known as suboxone. As of July 1, 2021, possession of 225mg or more would be criminalized. Senator Sears noted that this bill "for all intents and purposes legalizes" possession of amounts less than 225mg. For Vermonters under age 21, they would receive a civil violation, and those under age 16 would be committing a delinquent act.

Sarah George, State's Attorney for Chittenden County shared that in 2018 her office announced they would no longer prosecute for buprenorphine. Noting that these drugs are lifesaving, she said that people who are prescribed are less likely to commit crimes, and there is a drastic reduction of overdose and recidivism. Other jurisdictions across the country have followed suit, recognizing Chittenden County in their own policies. This bill is a modest step at "sending the message that we care about [people who use drugs], we want them to survive, and we encourage them to possess bupe." Since this decision in Chittenden County (but pre-COVID), overdose numbers have decreased, and the number of doctors who prescribe went up. She noted a recent federal decision to remove prescribing barriers. Rapid prescriptions at UVM's Emergency Department are helpful, but it is not available statewide. Insurance is an issue; it's easier to buy heroin than a diverted bupe strip. She noted that most people start their path to recovery through non-prescribed bupe.

David Scherr, the Assistant Attorney General and Chief of the Community Justice Division, spoke in favor of the bill. He said, "we are seeing a serious opiate problem in our state. We want to make sure people are not punished for using something less harmful, and safer." Senator Sears asked about how the current law can "be a tool to get people into treatment. Will this lessen that tool?" Scherr responded that we don't need to use the criminal justice system to do that. Law enforcement agencies are already working to create these pathways. Dennis Wygmans, State's Attorney from Addison County, shared his personal experience of living with someone who went through recovery twice. "Each time, he turned to street bupe first."

Senator Sears said that in his 40 years of experience, sometimes it does work to "lead a horse to water" i.e. mandate treatment. Senator Lyons wants to hear from providers on the ground about whether there is enough case management in the hub and spoke system. Bennington County State's Attorney Erica Marthage said that 80% of people use street bupe before accessing treatment. A local mom's group, Fed Up, supports this bill: "It if saves one life, it could be worth it." Senator Sears noted that people in Bennington have to leave the state to get treatment.

George spoke of the value of Safe Recovery, at the Howard Center. "Dr Blake, who lost her son, has been huge... There are so many people who are not ready for abstinence or full medication-assisted treatment because of trauma that led to their use. We have to be okay with that." Wygmans noted some initiations in Vergennes and Bristol and reported that CSAC just hired an outreach worker help with access to treatment and housing.

Mike Schirling, Commissioner of Public Safety, testified that less than 10% of cases where law enforcement, EMS, and fire encounter people in the community make it to a prosecutor's desk, so their field of view is diminished. Schirling believes people in possession should come into the criminal justice system, and then diversion, which serves as a connective tissue. He proposed altering the bill language to *create a presumption of diversion* for possession of 224mg or less. Lyons spoke of the importance of having responsive social workers in local communities and in local crisis units. "When one person is stopped in a traffic stop now, there is not a direct link to get to treatment, to get to the DAs."

The Committees heard testimony from Brenda Siegel, who is an advocate who lost both her nephew and brother to heroin overdoses. Her nephew experienced trauma from being abused in an institution and struggled to find mental health supports. He couldn't consistently access bupe or medication-assisted treatment. When he missed a single day, he would be removed for 60 days, and family members would help him access bupe illicitly. If a provider in his region closed, he had nowhere to turn. Relapse brought incredible shame and stigma. Other barriers for people can include long commutes, threats of losing children, shame, not feeling worthy, lack of funds, lack of ID, and lack of insurance. Entering the criminal justice system was the straw that broke her brother. She believes you cannot manipulate people into treatment. She encouraged the committee to pass this bill this year, as drafted, to prevent more deaths.

VDH Commissioner Mark Levine testified that he would support this bill in any other state than Vermont because Vermont has no waitlists for treatment. He is concerned, not only for people who deal with opiate addiction, but also Vermonters who are not currently using opioids and might be exposed; Vermonters who are in treatment to whom this gives a greater incentive to divert bupe and impact the success of treatment; and prescribers who may be more reluctant to participate. "We don't know what flooding the state with Buprenorphine will mean," he said. He is also concerned that "we lose a critical intervention point. We want people to be immediately referred to a caseworker at the police barracks or a social worker embedded with state police... criminal citation encourages diversion and treatment," which then goes away when the person enters treatment. He sees the value in coerced care from the drug court model – it can have the same result as voluntary care. He listed several new initiatives to support Vermonters with addiction, including rapid access in Emergency Departments, expansion of syringe services, and new connections between law enforcement and social services.

Brady Heward, child and addiction psychiatrist from UVM Medical Center's addiction treatment program and Champlain Valley [CVPH] child and adolescent inpatient program testified that adolescent opioid abuse is usually from prescription use. Julea Larson, from the Recovery Center of Bennington County, shared that she goes door to door with a local prescriber. People use street suboxone for various reasons. "If we meet with them at 4pm on Friday," she noted, "there are no services available until Monday morning." When individuals are ready at that moment, it's a problem that they can't get treatment right away. She would much rather see people have bupe than heroin or oxycotin.

Jess Kirby from Safe Recovery at Howard Center shared that she is a person in recovery. Unprescribed bupe was an important part of her journey. She said she didn't trust medical and social services, but she really wanted to stop using. When she used street bupe, she was filled with relief because she realized there was a way to be free from withdrawal symptoms. Appointments, urine analysis, and judgment and stigma at EDs can be all barriers to accessing treatment.

In the Senate Judiciary committee discussion the following day, committee members noted that Dr. Levine's comment that he would support this bill in any other state if there were wait times to treatment did not square with the reality that some people do wait for treatment in Vermont. The

committee appeared to unanimously support passing the bill this session, although Senator Sears plans to tweak the language. Senate Health and Welfare will hear testimony this week.

House Human Services Review Bill of Working Group on Services to Adults with Autism

Legislative Counsel Katie McLinn walked the Committee through H.243, An act relating to the Working Group on Services for Adults with Autism. The bill proposes to set up a working group to look at the system for providing services to adults with autism including identifying gaps in services and making recommendations for additional services that could be beneficial for this population. The workgroup would include the Director of the Developmental Disabilities Services Division at DAIL, a member named by the Commissioner of Mental Health, three members from DA/SSAs representing diverse regions of the state, appointed by Vermont Care Partners, a representative from UVM's Center on Disability and Community Inclusion, two members appointed by the Developmental Disability Council, an employee of Green Mountain Self-Advocates, a representative of the State Standing Council, a person with clinical experience with autism as well as others.

The bill empowers the workgroup to look at:

- Existing services as well as any gaps;
- Paying family members who provide full-time care for someone with autism;
- Collect input from persons with autism and their families;
- Review services offered by other states and identifying if those services would fit into the Vermont System of Care Plan;
- Determine the appropriate education and training for individuals working with people with autism;
- Make recommendations for changes to supported employment to better serve individuals with autism;
- Make recommendations on housing and respite options;
- Develop capacity to make sure families and individuals receive advice and support navigating decision making within the system; and
- Exploring the need for additional staff within DAIL.

The workgroup is to submit a report back to the legislature of their findings and recommendations by November 15, 2021.

Representative McFaun, the lead sponsor of the bill shared that he had been working with a group of parents, DAIL staff and DA/SSA staff to draft the bill and his workgroup was in agreement on all provisions of the bill with the exception of paying families for providing care.

Selina Hickman, from the Developmental Disability Division, pointed out that typically changes are made to the service array through amendments to the state System of Care Plan (SOCP) which is opened to amendment every three years. Due to COVID that did not happen this past year as it should have but the Division is on track to amend the SOCP this year. She said the state is ready and willing to engage in the workplan offered in the bill.

Representative Wood asked if the current SOCP addresses any of the areas covered in the recommendations that are proposed in the bill. Selina replied that the bill elevates a sub-population of individuals that DAIL serves beyond the typically robust stakeholder engagement that DAIL pursues during the renewal of the SOCP leaving her torn between the value of doing a deeper dive into the needs of any population that DAIL serves versus the cohesive approach taken during the SOCP renewal

process. Services within the SOCP are person-centered and individual as per our state system of DS values. Selina also testified that the Division has already committed (post-pandemic) to take up the issue of paying families for care.

Beth Sightler, Executive Director, Champlain Community Services, testified about the values and philosophy of Vermont's system of care. She talked about individuals needing a full array of opportunities and choices in conjunction with community inclusion in natural settings. She spoke about people who never knew about Brandon Training School and therefore don't see institutions or specialized segregated settings through the same lens as previous generations and again, how VT's SOCP supports person-centered services within the community. She spoke about the importance of listening to self-advocates as well as families and the meaning of "nothing about us without us."

Delaina Norton, Director of Long Term Supports and Services, Howard Center, testified about the strengths of both the state SOCP and local system of care plans, with their accountability and quality reviews. She spoke of the ability of DAs and SSAs, working with their State partners, to pivot and meet rapidly changing needs during the pandemic and beyond, including making payments to families. She pointed out that the local and state process for developing the SOCP's creates multiple opportunities for stakeholder engagement, helping to ensure all voices are heard, not just the loudest voices. She also shared that most people diagnosed with autism have multiple diagnoses and it is important to serve the entire person.

Representative Wood reminded that committee that a VT value is the "presumption of competence" when we are talking about people with I/DD and those closest to the person (the families) often are the ones who have the most difficulty in presuming competence. She asked Delaina to talk about the difficulties agencies face when trying to balance individual's voices with those of their family members. Delaina concurred that it is something she struggles with and she is thankful for examples she can share with parents about the dignity of risk and the positive outcomes of supporting the individual becoming independent, even when it is hard for the parent.

Kirsten Murphy testified that H.243 speaks to very real and urgent needs. She shared that every five years the DD Council is mandated to do a broad needs assessment in all the life areas for people with I/DD: housing, community services, employment, etc. They are currently in the needs assessment process. They have heard from families and individuals the following needs: better clinical services for people with co-occurring disorder and additional housing options. She pointed out the opportunity in the increased FMAP and other parts of the Biden plan that could be used creatively to support people with I/DD. She believes these changes in funding could impact the focus of H.243, which she believed was too narrowly focused diagnostically. She also felt that there were already many avenues for stakeholder engagement in DAIL on the issues of H.243. She testified that the legislature could direct DAIL to work on the issues outlined in the bill in the avenues (such as State Standing Committee, etc.) that already exist without convening a narrowly focused workgroup.

Senate Health and Welfare Committee Approves H.210 with Improvements

The Senate Health and Welfare Committee voted out H.210, An Act relating to addressing disparities and promoting equity in the health care system. It will be considered by the full Senate this week. The Committee added new findings related to the health disparities for native Americans, as well as Eugenics language from the joint resolution passed by the Legislature. The House bill defined racial minorities as "non-white". The Senate bill requests a report back on definition of racial categories. It also adds cultural humility to the definition and language on cultural competency. The Advisory Committee is expanded to include the executive director of the Developmental Disability Council and a substance use

disorder specialist from state government. Finally, the bill sets a date for establishment of office of health equity in the Department of Health for January 2023.

House Health Care Committee Learns about Global Commitment Waiver

Ashely Berliner, Director of Medicaid Policy, DVHA, explained that the waiver expires at the end of the calendar year. The 1115 waiver was used to expand health care coverage, investments in public health and health related services. The waiver submission for new waiver will be submitted June 30th to preserve flexibilities. Vermont's waiver supports traditional State Plan services and home and community-based services totally \$1.451 billion, plus \$136.03 million for investments and expansion such as choices for care, premium assistance subsidy, CRT, pharmacy subsidies and other investments. Right now, it covers the Institutes of Medical Disease (IMD), but the IMD investments are now being phased down.

Sarah Clark, CFO for AHS explained the budget neutrality requirements of demonstration waiver. The total Medicaid expenditures must not exceed what would have occurred without the waiver given negotiated per member per month (PMPM) rates and the growth trends. Given increased enrollment in Medicaid during the pandemic and the federal requirement to suspend redeterminations. Vermont's spending cap has grown during the last year, but our actual spending was down in 2020 due by low utilization rates. When asked why we aren't spending up to the full cap, Sarah said we need to have adequate state match for the level of spending.

There are criteria for investments:

- Reduce the rate of uninsured and/or underinsured.
- Increase access to quality health care by uninsured, underinsured and Medicaid beneficiaries.
- Provide public health approaches and other innovative programs to improve health outcomes, health status and quality of life.
- Encourage the formation and maintenance of public-private partnerships.

We have lost some flexibilities since our original waiver in 2005. In renewal the State is hoping to preserve and enhance flexibilities. The length of stay in IMDs is only 60 days and people in custody of DOC may not be funded with Medicaid for inpatient care. AHS is looking to have DVHA have greater flexibilities as a public managed care organization and will explore opportunities for more robust assistance for homeless populations.

The next day Representative Donahue said that the Medicaid cost shift is increasing. The savings of the global commitment waiver are being paid by health insurance rate payers. She would like the Committee to examine what is causing the cost-shift and the impact of it. Chair Lippert agreed.

House Health Care Learns more about OneCare Vermont

Victoria Loner, CEO, OneCare Vermont testified that providers have come together to form OneCare to solve the problems of payment incentives not being aligned and health care services that are not coordinated. The core business of OneCare is to create a high performing provider network, conduct data analytics and achieve payment reform with the goal of improving quality and care coordination. She said, nationally, accountable care organizations (ACOs) have consistently achieved savings over a five-year period.

Vicki said one of the functions of the ACO is to bring providers together to coordinate care. OneCare identifies who is in need of care coordination using claims data. They can also inform providers when a

person lands in the hospital ED or inpatient care. She said the “care model includes prevention, self-management of chronic diseases, care coordination, and end of life care”. She said blueprint focuses on short term needs, while OneCare’s care coordination is more long-term oriented for the top 15% of people who have high health care risk. There are 270,000 attributed lives, currently.

The presentation states that OneCare measures “cost, quality, and utilization across the whole health care system. We give providers more focused, actionable data to better serve their patients” It specifies different quality improvement projects. Vicki said the mental health and SUD measures are difficult to measure. The results for calendar year 2019 showed OneCare achieving the benchmark for 30-Day Follow-Up After Discharge from ED for Mental Health, but not meeting the benchmark for Initiation of Alcohol and Other Drug Dependence Treatment, Screening for Clinical Depression and Follow-Up, Initiation of Alcohol and Other Drug Dependence Treatment or 30 day follow-up after alcohol or drug dependence. \$3.9 million annually is used for care coordination from DSR funds awarded by the state. Vicki said the hospitals are investing more in population health than they are able to achieve in savings. As such, they are looking at whether the return on investment for the care coordination programs is it.

Total health care expenditures in Vermont are approximately \$6 billion. OneCare is currently accountable for \$1.4 billion and has \$38 million for investments. Monthly payments go directly from OneCare to its health delivery system totaling \$938 million annually. Of which \$474 million is in the form of hospital fixed prospective payment allocations and \$38 million is in the form of health care reform investments for OneCare population health management.

Vicki was clear that OneCare is not focused on affordability, but it is working to reduce health care costs. She said 70% of investment funds go to primary care and 30% goes to other providers such as designated agencies.

The OneCare budget is estimated to be \$16 million of which \$3.5 to \$4 is for data management. There are 60 people on staff.

Representative Lippert explained that the Committee is concerned that the model seems to incentivize reductions in care. They don’t want care rationed for financial gain. Representative Donahue said that the quality measures are extremely limited and weak. Her response is that the federal government sets the measures. To supplement those measures OneCare measures patient satisfaction and ensures that people see their primary care physicians. OneCare also reviews utilization of care by people enrolled verses people not enrolled in the ACO. She said the evaluation framework can be discussed.

Senate Judiciary Committee Completes S.3 on Competency and Insanity

After thorough deliberation and input from the House Health Care and House Corrections and Institutions Committee, the House Judiciary Committee unanimously passed S.3 An act relating to competency to stand trial and insanity as a defense. The next stop for the bill will be the House Appropriations Committee a vote by the full House of Representatives. The Senate will probably concur with the bill as amended by the House.

The Committee made several important changes to the bill, including the language on the initial psychiatric evaluation. If the individual is believed to have a developmental disability the examination shall include an evaluation by a psychologist in addition the examination by a psychiatrist. If the Court orders both an examination of competency and sanity, two separate reports are issued. The sanity evaluation will only be conducted if the person is found competent to stand trial unless the defendant requests to have both the sanity and competency evaluations conducted simultaneously. If the sanity

evaluation is not done until later, then information on sanity will be collected and preserved in case it is needed at a later date.

If the person is found to be a danger they are placed in the custody of DMH or Department of Disabilities, Aging and Independent Living (DAIL) by the Court. VT Legal Aid may represent them and DMH or DAIL may be present at the hearing. If the person is committed to the custody of DMH and their treatment status changes from inpatient to discharge to a residential or order of non-hospitalization (ONH) in the community, or if the ONH expires; or if they elope from custody; DMH must notify the state's attorney who then notifies the victim of the offense for which the person is charged. The Forensic working group, established by the bill, will study what to require in statute for victim notification If a person violates an ONH.

The Bill calls for an inventory of mental health services in correctional facilities by January 2022. The language was crafted by the House Health care committee and reads as follows:

The evaluation shall include:

- (1) 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, recognizing that comparison to currently available community services does not necessarily establish the standard of care for best practices;
 - (2) a comparison as to how the type, frequency, and timeliness of mental health services differ among Vermont correctional settings, including between men and women's facilities, and from those mental health services provided to individuals under the care and custody of the Department of Corrections incarcerated in an out-of-state correctional facility.
 - (3) an assessment as to how the use of a for-profit entity with whom the Department of Corrections contracts for health care services affects costs or quality of care in correctional settings;
 - (4) an assessment as to whether the Department of Mental Health should provide oversight authority for mental health services provided by the entity with whom the Department of Corrections contracts for health care services; and
 - (5) information as to how the memorandum of understanding executed by the Departments of Corrections and of Mental Health impacts the mental health services provided by the entity with whom the Department of Corrections contracts for health care services and whether it is adequately addressing needs of those individuals with severe illness or in need of inpatient care.
- (c) In conducting the work required by this section, the Departments of Corrections and of Mental Health shall ensure that social and racial equity issues are considered, including issues related to transgender and gender non-conforming persons.

The House Committees also added more members with lived experience and victims of crime to the Forensic Care Working Group. Vermont Care Partners will have one representative. The group has a long list of responsibilities that are scheduled to be completed over the course of 1.5 years. Highlights of the Committee's responsibilities include:

- recommending whether a forensic treatment facility is needed and what such a facility should be like;
- identifying any gaps in the current mental health and criminal justice system and opportunities to improve public safety and address the treatment needs for individuals incompetent to stand trial or who are adjudicated not guilty by reason of insanity;
- consider the importance of victims' rights in the forensic care process;
- Study competency restoration models used in other states;
- assesses the necessity of notification to the prosecutor upon becoming aware that individuals on orders of non-hospitalization are not complying or that the alternative treatment is not adequate to meet the individual's treatment needs; and

- Social and racial equity issues are to be considered including issues related to transgender and gender non-conforming persons.

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.