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Legislative Update for February 22, 2022

WHAT'S HAPPENING IN THE LEGISLATURE

The House and Senate will be working out their differences in the FY22 Budget Adjustment Act in the coming days. Vermont Care Partners and member agencies want the Legislature to come to agreement on one-time funds to stabilize our workforce that will be both sufficient and flexible enough to effectively address workforce challenges in the short-term.

On the long-term front we have been actively advocating for a 10% Medicaid rate increase to reduce our workforce crisis and improve access and quality of care to Vermonters whose need for our services have never been greater. The House Policy Committees will be making recommendations to the House Appropriations Committees on the FY23 budget. The House Human Services Committee will make recommendations on the Intellectual and Developmental Disability (I/DD) and substance use disorder (SUD) services, the House Health Care Committee will make recommendations on the mental health budget, and the House Commerce and Economic Development Committee will make recommendations on workforce development. All recommendations are due by February 23rd.

The House Appropriations Committee will then weigh priorities and should finalize the FY23 budget within a week or so for the full House to vote on. Advocacy to all House members over the next 2 weeks would be most helpful.

The Senate Appropriations Committee is already taking testimony on the budget and several members including the Chair have expressed concern about DA/SSA COLA.

Vermont Care Partners Legislative Agenda for 2022

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/2021/12/legislative-agenda-2022-working-draft-1-1.pdf>

This Week's Testimony and Legislative Action

House Health Care Committee Discusses FY23 Budget Recommendations

The House Health Care Committee Chair said the testimony provided by Vermont Care Partners and its members had a visceral effect on the Committee which now appears to be heading toward recommending a 10% rate increase for Department of Mental Health (DMH) funded providers. They will be coordinating their request with the House Human Services Committee.

There was discussion about achieving a \$20/hour minimum wage. Vermont Care Partners has communicated the need for compensation improvements for a range of staff, including clinicians and specifically school-based staff. House Health Care Chair Lippert plans to ask for an analysis of funding necessary to bring designated and specialized service agency (DA/SSA) compensation into rough alignment with state, school and health care professionals doing similar work.

Vermont Care Partners has requested to House Health and Human Services to recommend \$6 million annually for all staff (including I/DD) for tuition assistance and loan repayment. House Health Care has begun discussing a smaller amount. Additionally, House Health Care will be requesting that the Office of Professional Regulation evaluate barriers to licensure for MH/SUD professionals. Peer certification will also be including their recommendations.

The Committee appreciates the value of the work of DA/SSAs. Committee Vice Chair Ann Donahue said, "it's a stain on the State of VT that we are allowing children and adolescents to wait for weeks in emergency rooms because they can't access care." She believes the solution isn't building more inpatient beds, investment of earlier intervention would be more cost effective. She pointed out that having people waiting for outpatient services leads to use of higher levels of care.

Pathways Requests Expansion at House Health Care

The House Health Care Committee heard from Lindsey Mesa and Hilary Melton of Pathways Vermont, requesting \$390,000 for Pathways to expand into Bennington. Pathways was recently involved in doing work in the region through a blended contract with the Department of Mental Health (DMH) and the Department of Corrections (DOC) funding and secured 11 units of housing in Bennington since July. In doing this work, they heard about the extreme unmet need. Pathways shared their Housing First model, whereby housing is a basic human need and the only response to homelessness is housing (in contrast to a housing readiness model). This model is on SAMSHA's evidence-based registry.

The \$390,000 would fund work to support an additional 30 households for people exiting homelessness. Pathways' Housing First Programs are currently in six counties with a budget of \$1.8 million. DMH is aware of the proposal, but it was not in the Governor's proposed budget. Representative Donahue noted mobile outreach initiatives and the peer services bill in the Senate.

Mesa was asked about the relationship between the people who work with Housing First and the designated agencies. She says it varies from individual to individual. As an SSA, Pathways can serve the same people. Pathways uses modified ACT (Assertive Community Treatment) teams. "Sometimes we may partner with the DAs if it's a complex case," she said. Bennington has one of the highest rates of chronic homelessness in the state --70 households in the last count. Housing stock is at an all-time low, but Pathways has been successful there. So far, they have supported 34 households. Pathways is not immune to staffing challenges. Pathways is a provider of Supportive Services for Veterans' Families [SSVF] for veterans who are newly homeless or at risk of homelessness. She noted that homelessness for this population increased during the pandemic. People are living in cars, motels, and hospitals, and some

as old as 100 years of age. These are veterans who are likely to die without a permanent housing intervention.

The Committee plans to support the request from Pathways for Housing to expand services into Bennington County.

House Corrections and Institutions Determines Investment of Justice Reinvestment Savings

The House Corrections and Institutions discussed how to investment Justice Reinvestment savings that come from reducing the use of out-of-state beds. The Committee is considering housing, domestic violence, mental health, and data systems improvement. Department of Corrections (DOC) Commissioner Deml recommended three additional areas for investment: community justice centers, women's programs, and reentry and vocational programming and preparedness. Matt D'Agostino the Interim Deputy Commissioner explained that in total there is \$1.2 million base funding of which \$400,000 is in the DMH budget for the forensic assertive community treatment (ACT) program with the potential for an additional \$200,000 from the federal mental health block grant. DOC would like flexibility from the Legislature. The Committee directed DOC to go back to the drawing board to clarify their proposal, including base versus one-time funds.

House Human Services Consider Committee Bill on Intellectual and Developmental Disabilities

Committee Vice Chair Theresa Wood summarized themes heard in testimony: request for residential alternative pilots, failure to plan, poor communication with families, COVID, and workforce issues. Representative Brumsted strongly advocated for the development of pilots and Representative Wood would like to see 4 – 5 pilots employing different residential models. She feels that we need to do a better job to determining what people want. Representative McFaun wants to see pilots for people ages 22- 60. He also expressed concern that self-advocates are not getting what they need and that parents don't feel their participation makes a difference. Representative Wood estimates that it will cost \$100,000 in seed money for each pilot. She shared information on the how individualized shared living is and the variety of supports available.

Representative Wood believes that there is variability in eligibility determination by agency psychologists.

Representative Wood wants to reverse the requirement made by the legislature previously requiring approval of the Committee on Administrative Rules for regulation revisions.

Representative Wood pointed out that it is likely that the system will need additional funding to implement conflict of interest free case management (COIFCM). The current case managers do supervision of programs, substitution for staff, local quality assurance and training. These functions will continue to need funding. She explained the State tried to get approval for choice of case managers, but it wasn't approved.

Representative Brumsted asked about workforce issues. She was struck by Greg Mair's testimony that some workers couldn't afford the necessary tires to do their work. The Committee discussed a 10% rate increase and would like staff to receive a minimum wage of \$20/hour. Representative Wood noted that it would take a 13% increase to achieve that. It was mentioned that hospitals are giving 20% increases which will have a ripple effect. The first draft of the bill will be reviewed next Wednesday.

Parents from Developmental Disabilities Community Testify to House Committee on Human Services

Jim Caffrey, parent to a 21-year old son with autism, testified on his experience with residential options, referencing the Developmental Disabilities Act principles of full information and meaningful choices. His preference is for a group home setting for stability and 24/7 support. He recommends exploring a range of residential choices and opportunities such as paying families for care, various housing models, raising DA/SSA staff wages, and recruitment from AmeriCorps or the J-1 visa program.

Susan Yuan, parent to an adult son with Angelman syndrome shared her family's positive Shared Living Provider experience, which includes a lifelong commitment from the provider. She also expressed grave concerns about the disconnect between DAIL and the developmental disabilities community, as evidenced by the handling of payment reform which will have significant impact on funding and programs.

Elizabeth Milizia, self-managing parent of an adult son with Down Syndrome expressed her worries about her aging and lack of family supports for her son after she passes away. He will inherit the family home but will need support from an agency for him to stay there and navigate options if it doesn't work out.

Green Mountain Self Advocates (GMSA) testifies to House Human Services Committee

Max Barrows, Outreach Director of GMSA introduced the discussion with 4 major areas of concern: funding of residential service options, Vermont compliance with Center for Medicare and Medicaid Services (CMS) rules, peer supports, and the supervision and quality of developmental services in the State.

Witnesses were present from around the state: Hasan Ko of Winooski, Faith DeFelice of Barre, Sterling Peebles of Montpelier, Chad Cleverly of St. Johnsbury, Randy Lizotte of St. Albans, and Chris Medina of Barre. All shared personal experiences of the developmental services system in Vermont, before and during the COVID pandemic. Common themes emerged around a lack of residential service options, the need for neutral case management and ombudsperson services, lack of inclusion in state planning processes, the need for peer support programs, and loss of staff and program consistency due to low staff wages. Witnesses urged the committee to make decisions in the spirit of the Americans with Disabilities Act, cautioned against segregated or large residential models, and recommended that people receiving services should comprise 50% of any planning committees.

House Human Services Committee Hears More testimony about Yellow House in Middlebury

Greg Mairs, Operational Director in his 20th year of employment at CSAC discussed Yellow House and residential options within the DS system. Vermont has been a leader in community inclusion, despite chronic underfunding. He noted a lack of family voices in state-level decision-making. COVID has forced providers to develop creative new programming options, and to acknowledge the desire for people with disabilities to spend more time together.

Greg Mairs stated that it's important to fund the system so that everyone receiving services has equal access to housing opportunities, not a select few, and to find a way to investigate the right models of choice for Vermonters with developmental disabilities.

The Committee asked for further information about the impacts of underfunding. There is a 55% direct support professional vacancy rate at CSAC, and some staff qualify for food stamps or can't afford snow tires because their pay is so low and shared living providers have not been receiving increases on an ongoing basis. There are many people receiving services who are in less-than-ideal living circumstances,

so while not technically homeless, are not living their full lives. A shortage of rentals and Section 8 vouchers adds to housing stressors.

Mr. Mairs expressed hope for an ongoing collaboration around the System of Care Plan process, and a strengthening of state, family and provider relationships that will allow for a vigorous pursuit of future innovations in residential choices, while remembering past lessons on institutionalization.

House Health Care Considers Hospital Sustainability and Proposal by Green Mountain Care Board

As a follow up to Green Mountain Care Board (GMCB) report and recommendations on hospital sustainability, Devon Green of VAHHS presented positive data on hospital savings, including reductions in unplanned hospital admissions before the pandemic. In discussing the current challenges of hospitals, Devon Green shared that 35 people are in emergency departments waiting for inpatient psychiatric care and many patients are waiting in hospitals for discharge who cannot access subacute care due to workforce crisis in home health and long-term care facilities. She also noted people being dropped off in EDs not because of emergent care needs, but because they have nowhere else to go.

When asked if VAHHS supports the proposal of the GMCB plan for sustainability Devon Green said she wants to start with asking communities what they need, instead of top-down approach. If this is the direction the committee is going VAHHS will cooperate, but if the committee wants to invest the funds in expanding subacute care VAHHS would support that, as well. They are willing to have a discussion about value-based care, but she wants to manage expectations of what value-based care can achieve.

From VAHHS's perspective the system is already lean; there are not a lot of savings available in Vermont. Devon Green supports aligning incentives to improve health so that the cost of health goes down over a period of decades. Most of all, she said, we need a predictable and sustainable direction going forward. Hospitals are investing in workforce and immediate needs, but with competing goals hospitals are hesitant to invest in long term goals. She asked for increased Medicaid reimbursement for all health care and she would like continued investment in care coordination by providers, not by the payers. Additionally, VAHHS would want any new payment model to include hospitals in the decision making.

GMCB Chair Kevin Mullen, Executive Director Susan Barrett, and Director of Health Systems Policy Alana Berube shared information on their proposal. Kevin Mullen said we do not have mental health parity when people are waiting for weeks for mental health care in emergency departments. For any mental health system to work we need a community-based system.

Alana Berube described their \$5 million ask. GMCB is in discussion with the AHS Director of Health Care Reform about this proposal. It is AHS, not GMCB that negotiates waivers with the Centers for Medicaid and Medicare Innovation (CMMI). The following is a slightly shortened excerpt from the document submitted to the Committee by GMCB.

Summary of Key Findings

1. Absent reform, Vermont hospitals' financial health will continue to decline and commercial prices will likely continue to outpace economic growth, making health care even less affordable, eroding quality of care over time, and threatening Vermonters' continued access to care in their communities.
2. There is significant reimbursement disparity across hospitals in the extent to which their reimbursements cover their costs of delivering a particular service, even after controlling for case-mix.
3. Accelerated delivery system transformation is the only solution to address both hospital financial sustainability and ensure Vermonters' access to high quality, affordable care.

Recommendations

1. Accelerate shift to value-based payment & delivery

- a. \$1.4 million – Design Hospital Global Payments that are predictable, flexible, and sufficient to equitably deliver high-quality, affordable care.
 - b. \$600,000 – Design and Development of Potential Subsequent Federal Agreement with CMMI to include Medicare in the hospital global payment and Vermont care transformation initiatives.
 - c. \$3 million – Community Care Delivery Transformation & Technical Assistance to Communities, engaging health systems optimization experts in a patient-focused, community-inclusive redesign to reduce inefficiencies, lower costs and improve population health outcomes; support hospitals in delivery system transformation.
2. Incorporate quality into the hospital budget review process: GMCB to continue partnership with VPQHC and stakeholders to develop a hospital quality framework and ensure its incorporation into the hospital budget review process.
3. Ensure sustainable Medicaid payments
- a. Support DVHA work to professionalize Medicaid reimbursement methods in FY23; appropriate necessary funds.
 - b. Analyze potential enhancements to budgeting process to consider medical inflation and sustainability.
 - c. Ensure timely reporting from DVHA to GMCB of any Medicaid impacts on hospitals to ensure the hospital budget process incorporates appropriate Medicaid assumptions.

During the discussion Kevin Mullen said we are still asking providers to reconcile to a fee-for-service world. That is not true capitation. Mullen wants collaboration, rather than consolidation. For instance, having different hospitals provide specific specialties in compliment to each other.

Devon Green said there would need to be funding for hospital transformation to a different payment model. Kevin Mullen agreed, noting that the All Payer Model was negatively impacted because the hundreds of thousands of dollars for delivery system reform never were invested. The Committee felt strongly that the investment is worthwhile and will require strong community process to explore global budgeting as a potential solution.

Health Equity Report Presented to House and Senate Health Committees

Xusana Davis gave a report on the work of the Health Care Equity Advisory Committee. It has 29-members broken up into seven subgroups to study: grants and funding; access to care; policy and programming; training; engagement and communication; data; and prevention, upstream factors and social determinant of health. She said “because of the breadth and depth of these topics, the Commission has chosen to perform its work at a pace that allows for thorough research and meaningful community input”.

There is a need for better data because medical research has focused on empowered groups - able bodied, white, males or European descent. Additionally, trust in health and government is strained. She noted the impact of eugenics on people with disabilities and indigenous people who have experienced intergenerational trauma. The technology to collect and analyze data is limited, for instance non-binary people have no category in many data collection instruments. They have discussed language barriers, barriers to people with disabilities and older adults and how health care is provided in silos. The Committee wants the data infrastructure to collect health care disparities developed in advance of completing its work.

Committee member Reverend Mark Hughes emphasized that dismantling racism is essential to improving health outcomes.

The initial Report to the Legislature Includes this statement on mental health

Mental and Emotional Health

- There needs to be more meaningful conversation about mental health. o The Commission will explore the intersection of mental health outcomes and race/ethnicity.
- The Commission commits to hearing more from psychiatric survivors, specifically about approaches to mental health services.
- There is a need for more peer support services in all systems.
- The Commission will explore practices in Emergency Departments, specifically involuntary hospitalizations and their connection to mass incarceration.

Department of Vermont Health Access (DVHA) Budget Reviewed at Senate Appropriations

DVHA Commissioner Andrea De La Bruere, DVHA CFO Steve Wisloski, Director of Managed Care Operations Alicia Cooper, Director Clinical Care Sandi Hoffman, and Health Care Director Nissa James provided the Senate Appropriations Committee with information of the DVHA FY23 budget request which calls for \$94.8 million in new spending of which \$43.6 million is in state general funds.

Commissioner De La Bruere highlighted that DVHA has not been able to conduct redeterminations for Medicaid coverage during the federal state of emergency which will take one year once the redeterminations are started. Currently, there are 30,000 more enrollees than March in 2020. They hope to hear soon about whether the state of emergency will be extended.

There are \$12.5 million in Medicaid rate increases. The budget includes \$500,000 for per diem payments for hospitals for people waiting in emergency departments for inpatient psychiatric care. Senator Kitchel would like to see this resource used to adjust the environments of the EDs as was conveyed in the Senate version of the budget adjustment act which is currently under negotiation.

Senator Starr asked about how the 3% rate increase was derived. Senator Kitchel shared her concern about the Governor's proposal for a 3% increase for DA/SSAs and community-based providers when state employees and others are getting 10% increases. She said, we are asking agencies to provide care, meet increased operating costs and work in a competitive environment. From her perspective the 3% increase is reflective of the priority which these providers are regarded by the Administration. Our view is that the 3% increase will worsen the situation, Senator Kitchel declared. She believes the impact is not understood or in this Administration these services are not a priority. She added, we are hearing that it will be impossible for these providers to do this work with this level of increase.

Healthcare Flexibility Bill in Senate Health and Welfare February 16, 2022

Mike Fisher, Health Care Advocate, and Jeff Hochburg, representing the Vermont Retail Druggists, both testified in favor of the provisions of H. 654 -- the "Flexibilities Bill" -- that allows for early refill and 30-day refill for maintenance medications for chronic conditions. Fisher noted that there is no indication that this has been abused. Hochburg noted that there continues to be reduced access to care, due to pharmacy closures, and that there are "safety tools" to mitigate risk of abuse are in place.

Nissa James, Health Care Director DVHA, provided [testimony](#) on the bill. She shared that this provision represented 1-2% of pharmacy claims at the beginning of the pandemic and is now closer to .02%. DVHA would like to see the language adjusted so that it *permits* DVHA to afford this flexibility but doesn't automatically authorize it. She has not heard of abuse or waste. She also requested permissive language that would permit DVHA to relax provider enrollment procedures, rather than to automatically relax them. DVHA wants to be ready when the federal public health emergency ends, and not end up with a backlog of providers that need to be revalidated and therefore cannot receive reimbursement.

The Committee noted that DVHA had made the same requests to House Health Care, but House Health Care Committee had stayed with their original language. Chair Lyons plans to talk to House Health Care Committee but appeared inclined to leave the bill as is.

Suicide Prevention in House Health Care Committee

House Health Care heard from a wide variety of witnesses advocating for suicide prevention resources. DMH Deputy Commissioner reviewed the priorities in the Governor's Budget, which include expanding Zero Suicide to all 10 designated agencies and boosting Zero Suicide at the original three DAs; appropriating funds to maintain 988 suicide prevention lifeline services that are currently provided by NCSS and NKHS; and boosting Eldercare funding for suicide prevention, noting that this is a vulnerable population. Krompf said that 141 Vermonters were lost to suicide in 2021, with 9 death certificates still pending.

Nick Nichols, the Suicide Prevention Grant Coordinator at the Vermont Department of Health, provided [an overview](#) on a comprehensive suicide prevention CDC grant underway at VDH and DMH. He described this as a public health effort, with the theme of "all Vermonters have a role in facing suicide." The grant will focus on vulnerable populations include males, rural Vermonters, people with disabilities, and LGBTQ Vermonters. Activities will include expanding gatekeeper training; reducing access to lethal means; improving connectedness for specific populations such as farmers, first responders, and suicide loss survivors; and expanding Zero Suicide efforts into healthcare including Emergency Departments. The grant also aims to expand access to suicide-safe mental health care through telehealth.

Terri Lively acknowledged that she wears many hats, for this testimony she was representing the Vermont Suicide Prevention Coalition and the Vermont Chapter of the American Foundation for Suicide Prevention in joint advocacy. Lively has also worked for NKHS for 17.5 years, and part of her role includes Emergency Services response and answering the suicide prevention hotline (soon to be 988). She also shared that she is a suicide attempt survivor, something she has only disclosed recently out of concerns about stigma, and she is also a suicide loss survivor.

The coalition [would like to see](#) significant budget increases:

- \$1.35 million sustainable ongoing funding for 988 (\$440,000 was budgeted): Calls are predicted to increase by 30% each year; and 988 will save people from using healthcare resources.
- \$1.2 million for Zero Suicide expansion (\$260,000 was budgeted).
- "We also need 10% increase for DAs and SSAs," she said, noting that staff are overworked, but working their hearts out, doing vital pre- and postvention work.

Lively also advocated for expansion of mobile crisis units in every sector of Vermont, vet-to-vet and Eldercare investments, and especially funding for a statewide Suicide Prevention Director position, which will "put all the services together." Lively said it's important to fully fund the array of services: "one area that is not funded will affect the other."

Emily Hackett-Fiske, shared her story of devastating loss of her 12-year-old son, who died by suicide using an unsecured firearm in another person's home. Hackett-Fiske shared that forensic evidence indicated that this was an impulsive decision that had not crossed his mind until five minutes before he died.

Rebecca Bell, Pediatric Intensivist, and Professor of Pediatrics at UVM and Tom Delaney, Associate professor at UVM, shared [data and a public health perspective](#) on suicide prevention. Rates of suicide in Vermont are higher than the national average and continue to increase. Males are at substantially

greater risk. Vermont has high rates of firearm related suicide death compared to other states. It's a myth that people who are suicidal find another way if they don't have access to a firearm. "Where there are more guns, there are more suicides." Noting impulsivity as a driver, 24% of people who die by suicide spent five minutes or less contemplating suicide. Delaney also noted that the risk of any violent death is about 20 times higher if there is a firearm in the home than if not. Representative Black underscored this, saying "Vermonters really need to know this."

Representative Goldman appreciates that suicide prevention is being treated as a public health issue. Dr. Bell noted that physicians can be nervous about talking to patients about firearms in their home, worried that it might impact the therapeutic relationship. They have a module they have created to train physicians to make it part of their pediatric safety conversations with families, akin to bike helmets. They are hoping to make this module available to mental health providers as well as the primary care field.

Senate Health and Welfare Hears from Office of Professional Regulation (OPR) on Peer Certification

Lauren Hebert of OPR recommended that they be allowed to develop the certified peer profession in collaboration with DMH to achieve a "fully cooked" recommendation for the Legislature next year. The core function of regulation of professions is public protection and there needs to be:

- Defined qualifications for the profession
- A process for application approval and renewal approval
- A public roster of who is certified
- A complaint, investigation and enforcement process

Still, Lauren Hebert said the credential should exist but should have the state seal of approval through regulation. OPR has the infrastructure to be a partner with DMH. She is not prepared to recommend modifications to the bill, S.195 now and will research how other states do it. Three ways to approach include OPR oversight, DMH oversight, and third-party oversight. She noted risk of public harm and use of public funds, as well as a concern about whether peer professionals could veer into the psychotherapy.

Peer Respite, Peer Certification, and Services for Students in Senate Health and Welfare

Shayla Livingston, Policy Director for AHS, updated the committee on DMH's position on the peer respite (S194) and peer certification (S195) bills via a [memo](#) from Commissioner Hawes. The memo cited work already done by the Peer Workforce Development Initiative (PWDI) and wanted to make sure the process laid out in S195 did not duplicate that work. Additionally, it suggested that the pilot programs suggested in S194 might not be feasible and appeared to suggest a delay in implementation. She also noted that it would be important to get feedback from DVHA on the Medicaid impacts of peer respite pilots.

The Committee acknowledged turnover at DMH but expressed that they wished that they had had this feedback earlier. Hooker said they want to move forward to meet increased need. Livingston noted that as soon as the Budget Adjustment Act passes, the grant to propose a peer certification framework is ready to go.

Responding to testimony submitted from the Office of Professional Regulation suggesting that OPR review whether or not to add peer support specialist certification, Lyons clarified that peer support is not psychotherapy. Lauren Layman, Staff Attorney at OPR, said that currently peer support is permissible without regulation. Because S195 asks for State Certification, OPR suggests that they go

through what they call the “Sunrise” process, considering whether there is a threat of public harm if there is not certification, and then determining the least restrictive form of regulation possible. OPR could produce a report by Dec 15, which would involve stakeholder input.

Hooker pushed back on the suggestion that expansion of respite beds should wait until after the peer certification process is finalized, noting that Alyssum is already doing great work. Senator Cummings cited Medicaid reimbursement as the biggest issue. “We don’t pay for AA treatment with Medicaid. We have a ceiling in our Medicaid waiver. If we take in another huge program, we may be stopping our ability to do something.” Lyons noted there might be a need to take an incremental approach.

Wilda White, Founder of MadFreedom, and proponent of the bills, said that “OPR wants to do the Sunrise because they don’t understand what peer services are. 48 states have peer services – most don’t have OPR involved. For peer support to work, it needs to look very different from a typical profession.” White explained the pilot element of S194 is the addition of peer respite on to existing Community Center programming in Montpelier and Burlington. She gave the example of a person who is needing support at 5pm after working through something at a Community Center. With a peer respite program, they could spend the night there instead of going to an Emergency Department. This “pilot” is separate from the other proposed new peer respite beds.

Senator Cummings noted that WCMHS has peer services, citing that 30% of their workforce is peers. “Will the people currently working for mental health [i.e. designated agencies] be able to get coverage [Medicaid reimbursement]?” Lyons noted that it will be important for the Committee to lay out how these proposals link with current respite beds and Medicaid services. Senator Hooker will work with Senator Lyons, DMH, MadFreedom, OPR, and Legislative Counsel to refine the bills based on the discussion.

ESSR Funds to Afterschool Programs in Grants from DMH in Senate Health and Welfare

Senator Lyons shared a new version of S197, previously a bill that had proposed a workgroup on Coordinated Responses to Mental Health Crises. She said the state is in a crisis with kids in schools. Schools don’t have the capacity to deal with the mental health issues they are seeing. Citing [testimony](#) provided by Vermont Afterschool CEO Holly Morehouse, she [shared the new version of S197](#), which requires an inventory of mental health crisis response programs and includes Morehouse’s proposed language, wherein DMH would allocate \$250,000 in ESSR grant funding to school-based and afterschool-based programs to “support the mental health and wellness needs of students, families, and staff...Grants shall be available to programs operating in a variety of settings outside the school day and over the summer, including before and after school, in-service days, and school vacation weeks.” Lyons noted that AOE disagrees with this interpretation of the use of ESSR funds.

Senator Cummings noted that her local mental health agency runs an alternative school, and kids have an existing relationship with a counselor. “Are we setting something up where they now start a new relationship with an Afterschool program counselor?” Cummings noted that current mental health services are already underfunded and is concerned about setting up something new, only to take it away in two years. Senator Lyons responded that this is more about Mental Health First Aid type of activities. Senator Hardy said that the program requirements, which include evidence-based one-on-one supports, coordination with school staff, pediatricians, and families, staff trainings, and data collection seems like a heavy lift for a small one-time grant. She noted \$4.2 million in recently announced federal funding for Afterschool programs. How is this different? Lyons said the material difference is that it’s mental health related.

Senator Cummings wants to hear from local mental health agencies on what they are doing. "I don't want to supplant their programs, and if there is extra money out there, they can all use it." Senator Lyons noted some schools have relationships, but it's not ubiquitous, and it's not covering the need. Senator Hardy wondered if the \$250,000 would be better used for supporting school-based clinicians to do afterschool or summer work. She said, "these school-based clinicians are super necessary and overwhelmed," and there is new funding for Afterschool programs. Lyons pledged to continue to look at the bill with the committee.

House Human Services Committee Plans to Develop Legislation on Opioids

Based upon the guidelines/parameters set forth in the National Opioid Settlement Agreement the House Human Services committee is being asked to help determine the lead agency within the State to manage and request funds from the national settlement and a create an 18 person committee to help determine allocation of the funds at the local level. The committee will consist of state regulators, agencies representatives and nine "paid" municipal workers. It will be presented to the full House and then returned to the Committee for further work. The title is: Creation of the Settlement Advisory and Opioid Abatement Fund.

The Opioid Settlement requires municipalities to have a strong role in the allocation of the resource the use of which is specified in the National Agreement. Karen Horn provided testimony for the League of Cities and Towns who would like to allocate funds to support community justice centers. She expressed concern about the League being asked to recommend judges for the committee and the potential for an unwieldy 18-member committee for determining allocation of funds. Department of Health representative, David Englander was not available but indicated they agree with settlement functions under consideration. It was suggested that Vermont Attorney General be included as a part of the committee determination.

The Committee also discussed the proposed FY 23 budget for substance use disorder services. They would like to build capacity for lower acuity beds and discussed staffing issues caused by underfunding leading to underutilization of residential treatment beds. They like the Governor's proposal to develop respite housing. There were concerns about the proposed \$270,000 workforce earmark for a pilot at the Burlington Turning Point related to workforce. Support provided onsite by VocReb consultants were underutilized. They had questions about the \$500,000 proposed for each of three years for Jenna's Promise. There was agreement that recovery centers are key to success and should receive adequate base funding.

Plan to Participate in these Advocacy Events

Save the Date! Vermont Disability Awareness Day

"Open to Change, Open to All" VCDR 2022 Platform Presentation

Wednesday, February 16 5:30-7:00 pm – Zoom

Join VCDR members and others from the disability community as we present our legislative priorities and share our stories about important issues. "COVID has challenged us to find ways to respond to new challenges with high expectations and a commitment to make sure that our best hopes for the future are Open to All." Deborah Lisi-Baker

Registration Link: <https://tinyurl.com/VCDRPresentation> This event will have ASL interpretation and live captioning Contact: Nick Morlan Nick@vcil.org or Call 802-224-1820

Vermont Disability Awareness Day will be observed in a three-part series. The first day is complete. Save these dates and watch for announcements coming soon:

- March 15th at 10:00 a.m. Home and housing is a high-priority topic at this moment in Vermont history. Format and details TBA
- April 13th – Time and keynote speaker TBA

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.

[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.

