VERMONT CARE PARTNERS

Supporting Vermonters to lead healthy and satisfying lives community by community

Legislative Update for April 5, 2022

WHAT'S HAPPENING IN THE LEGISLATURE

After Cross-over Legislators Focus on Bills to Pass this Session

Now that the Legislature is past crossover, it is critical for bills that passed one chamber to be considered and passed by the other chamber. The first chamber may choose to accept any changes made, offer minor amendments for the other chamber's consideration, or call for a committee of conference to work through differences, with the final bill requiring passage by both chambers. This last scenario is always how the budget bill is worked through. Once that bill and the revenue bill with necessary financing are passed, the session ends.

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

Senate Appropriations Continues Budget Testimony

The Green Mountain Care Board (GMCB) testified on their budget to the Senate Appropriations Committee. When the Board Chair Kevin Mullin was asked about the appropriate number of days of cash on hand for hospitals, he said generally it should be over 150 days, but it depends on multiple factors. He said the GMCB is considering about whether this is a time for hospitals to apply for mid-year increases or wait until the normal budgeting process and use reserves in the interim. He couldn't address any hospital-specific questions while hospital requests are under consideration by GMCB.

House Appropriations Committee Chair Mary Hooper briefly shared highlights of the FY23 budget as passed by the House. She said they wished they could have done more than the 7% rate increase for DA/SSAs but couldn't because of the Medicaid cap, but they see a "deep need there".

Interstate Telehealth in Senate Health and Welfare
The Senate Health and Welfare Committee took testimony on H.655, which sets up a framework of telehealth registration, telehealth licensure, and full licensure for out-of-state telehealth providers seeing Vermont patients or clients. Office of Professional Regulation (OPR) Director Lauren Hibbert noted that this bill represents the recommendations made by the Interstate Telehealth Workgroup and is a high priority for OPR. Strengths of the bill include that it is allows for profession-specific rulemaking and uses a tiered structure to provide more regulation over out-of-state telehealth than currently exists. The bill includes a $360,000 appropriation to set up the proposed structure, but the ultimate fiscal implications are unknown. Jessa Barnard from the Vermont Medical Society testified that she appreciates the flexibility and the guardrails in the bill, as well as the fact that the same regulations apply to all practitioners in Vermont.

Committee members asked about qualifications of out-of-state providers. Hibbert noted that OPR will likely do profession-specific rulemaking and that providers are required to meet Vermont standards of care. She said OPR has received seven complaints so far about telehealth services (since the pandemic). In explaining the telehealth registration function, Hibbert gave the example of a mental health provider who works with an incoming out-of-state UVM student; the registration would allow them to provide treatment until the student can transition to an in-state, in-person provider.

The committee then walked through the bill. Legislative Counsel Jennifer Carbee noted that telehealth applies to telehealth, store-and-forward, and audio-only care.

DMH Testifies on Wait Times in Emergency Departments (ED) in House Health Care
House Health Care Committee Chair Lippert opened the testimony noting that the Committee receives reports on wait times in EDs and it seemed imperative to re-engage with the Vermont Dept of Mental Health (DMH). Commissioner Emily Hawes, Deputy Commissioner Alison Krompf, and Mental Health Services Director Samantha Sweet testified. Hawes stated that no Vermonter should be waiting in EDs. Their testimony covered what DMH is doing right now, actions for the next 100 days, and long-term plans.

In terms of current actions, Sweet shared the triage work of the care management team. DMH facilitates a meeting with the department of children and Families (DCF) every day to work on moving youth in DCF custody through EDs and inpatient placements. This has led to increased communication with community partners. There is also a daily huddle facilitated by UVM Medical Center which includes DMH, and the Brattleboro Retreat. She noted that Champlain Valley Physician's Hospital (CVPH) has become more integrated into the Vermont system and is now added into the bed board. Eight out of 10 DAs have mental health workers embedded with law enforcement.

In terms of the next 100 Days, Krompf testified that DMH worked with DAs at the end of 2021 to fund a $2 million retention plan focused on 24/7 service providers. DMH has put together a mental health payment model which is allowing agencies to still take in their case rate payments so they can hire staff back. She highlighted a success story that Jarrett House, which had to close on weekends due to staffing shortages, is now back to 24/7 (noting that the State is not taking credit for it). During the pandemic, DMH made adjustments for QMHP trainings to be offered virtually. DMH is now seeing quality issues, so they are moving that training back to in-person. NFI Hospital Diversion is integral for children and youth; the State was able to support staffing to allow Hospital Diversion to resume 24/7 care, although she noted NFI South still has limited bed capacity. Jarrett House and NFI North are back to full capacity.

There are 13-15 youth currently waiting in EDs. They require complex community-based care, therapeutic foster care, and yet staffing in the community is incredibly depleted. DMH sees FMAP dollars as a resource to work toward initiatives such as Cahoots, PUCK, and Mobile Response and Stabilization Services. She also indicated that a recent review found that 65% of the youth who are waiting are waiting due to suicidality as a presenting concern.

Sweet shared that the Brattleboro Retreat has been able to expand inpatient capacity with AHS providing support for staffing. They have also transitioned some adult beds to child beds. VPCH has 21 beds, and Middlesex Therapeutic Community Residence has opened its seventh bed. Citing the need for secure transportation, due to lack of sheriffs, which results in longer waits, DMH recently contracted with a provider who will offer safe transport from EDs to inpatient units for youth and adults.

DMH fielded a question from Chair Lippert on "sitters" (staff assigned to support people waiting in EDs), noting he has visited and seen them on their phones outside the patient's room. Sweet acknowledged different expectations based on different hospitals, practices, and resources. Rep Peterson asked, "Is any psychiatry happening at all?" DMH shared that there is a new initiative happening in partnership with the Vermont Program for Quality in Healthcare for psychiatric telehealth in EDs, as well as a quality improvement workgroup through the Vermont Department of Health, focusing on suicide prevention in EDs. Krompf also noted that the majority of kids in EDs are presenting with suicidality. "We are in conversations on how we can work with Chittenden County about how they can reassess" to determine if safety concerns still require inpatient levels of care. DMH also spoke of receiving meaningful input from stakeholders over the summer and through the Mobile Crisis State Planning Grant.

Rep Cina said he gets mixed messages about his role as an outpatient therapist when a client is in the ED. Clients want therapy while they are sitting in the ED. "Reassessments are not therapy…why can't we pay therapists to provide that in EDs? There is pressure to not abandon the clients." Krompf said that payment reform removed barriers for DAs to provide care in that way, then noted that Cina is in private practice. She said this topic merits further attention.

Rep Houghton asked, "When will we see downstream benefits" of DMH's actions? Hawes responded that "we don't have a crystal ball." Krompf added that DMH is looking to diversify inpatient options for kids. UVM Health Network was the sole respondent for the RFI for 10 inpatient beds for kids. They expect it may take 2-3 years until it's operational. The committee ran out of time, and DMH will return to discuss long-term plans.

Joint Meeting of Senate Health and Welfare and House Health Care on Health Care Wait Times
Agency of Human Services Health Reform Director Ena Backus, Department of Financial Regulation (DFR) Mike Pieciak, and Green Mountain Care Board Executive Director Susan Barrett provided joint testimony on their work to assess health care wait times. They noted that health, emotional, financial, and equity are impacts of waiting for care. A total of 70 Vermonters provided public comments, describing physical and psychological pain, trouble with referral processes and bureaucratic hurdles for specialists. Their comments highlighted a particular need for psychiatry and eating disorder treatment. Provider input emphasized workforce shortages across all sectors; concerns about primary care doctors referring to unnecessary specialists "appropriateness", and administrative burden reduced access to care.
The assessment evaluated wait times using three methods: hiring a national actuarial firm to analyze wait times compared to other states; a "secret shopper" approach for non-emergent specialists; and a blueprint chart audit. Findings included:

- The average wait time to see a specialist is 100 days.
- Vermonters have longer wait times than peer states.
- 85% of specialists were accepting new patients; Medicaid wait times are slightly shorter than BCBS as seen via the secret shopper method.
- For addiction services, the average wait was 46 days; psychiatry averaged 54 days—57 days if only including in-state providers. (The blueprint chart audit found an average wait time of 67 days, and 82 days for psychiatry).
- The longest average wait was dermatology (109 days).

Recommendations from this work that relate to mental health providers include:

- Complete a mental health and substance use disorder access assessment
- Implement the health care workforce strategic plan which includes:
    - Evaluate barriers to licensure
    - Work toward Medicare reimbursing at parity with Medicaid for licensed mental health providers, such as Marriage and Family Therapists and Clinical Mental Health Counselors to improve access to care
    - Establish telepsychiatry in Emergency Departments statewide

Additionally, DFR would like statutory authority to track wait times, in partnership with healthcare providers. Pieciak noted that in soliciting extensive public comments, they heard no complaints related to actual quality of care. Committee members asked about whether prior authorization was a factor in delaying care; DFR said that, in general, they did not find this likely because insurers are subject to time constraints to render a decision within a week, and if the prior authorization is denied, there are internal and external appeal processes. Rep Lippert noted the significance of the finding that Medicaid patients are not waiting longer than patients with commercial insurance.

Peer Credentialing and Respite in House Health Care

The House Health Care Committee heard testimony on S.195, the bill that sets up a peer credentialing process. DMH Deputy Commissioner Alison Krompf testified that DMH supports "evaluating a process to look at peer certification." This will promote person-centered care, address workforce challenges, and could help with emergency department waits. She noted that Vermont has peer supports now, but the State hasn't defined that for Vermont in the way other states have. DMH and AHS were planning on working to making peer services a Medicaid billable service. Krompf is unsure about whether insurances reimburse for peer services.

Wilda White, Founder of MadFreedom, testified that she authored S.195 and S.194, which have been combined into the current S.195. She doesn't support this version and doesn't believe that the $30,000 designated will fully support the work outlined. The current bill is unfunded and doesn't require AHS to apply to CMS for amending the state plan. The bill went to Senate Appropriations with $525,000 attached to it for startup, for running the program, for certification, renewals, complaints, and for continuing education. These buckets are still in the bill, but none are fully funded.

There was discussion about the family support peer role versus peer-to-peer support. White noted that this bill proposes a mental health peer specialist certification with subspecialties, such as for youth, or geriatric specialty. Another subspeciality could be for family members. She noted that several states

offer credentials for family-to-family and peer support services, but they didn't always add those at the same time.

Rep Houghton asked what can be achieved with the $30,000 in this version of the bill. Krompf said the $30,000 is to create the working group to explore this. DMH concurs that it would not support the whole implementation, and that without adequate funding the bill is not viable.

OPR Director Lauren Hibbert testified that OPR is concerned about lack of state oversight over the credential, with the thought that Vermonters would assume State oversight if there is a credential. OPR also wants to ensure that the use of psychotherapy by peer support specialists is excluded unless the specialist is on the roster or otherwise credentialed. OPR is happy to write a report considering a structure for OPR certification where OPR would do applications and renewals, but not policy and training (they would partner with DMH and/or a third-party entity for this). White commented that peer supports specialists do not perform psychotherapy. If OPR takes over, the credentialing process would lose the benefits and values of peer support specialists, which is anti-professional. Some states do it through mental health departments, some through professional regulation office, some join a consortium, and some (like this bill) have an independent entity. Medicaid does not require the Office of Professional Regulation to regulate it. House Health Care will continue to take testimony.

Mitigating the Opioid Crisis in Senate Health and Welfare

Senate Health and Welfare introduced to two house bills, H.728 and H.711. Rep Dane Whitman introduced H.728 by noting that opioid deaths have quadrupled over the last ten years, with 181 deaths in 2021, 90% of which involved fentanyl. The three policy goals of H.728 are to expand access to safe syringe programs (and consider peer-operated needle exchange programs), address prior authorization barriers, and to consider feasibility and liability of expanding overdose prevention site activities through a working group, with a report due in November 2023. Howard Center's Safe Recovery Program Director is included in the working group.

The bill includes three pilots, which would be funded through ADAP-awarded grants: mobile access to hub and spoke services; increasing access to care for justice-involved Vermonters; and increasing collaboration between recovery and treatment providers and first responders. Whitman fielded a question about which organizations would receive the pilot funding. He said the language is intentionally vague to not rule any organization out. It is likely they will look for federal grant opportunities for this work. Rep Whitman noted that the intention of creating pilot programs was "to try some new things in anticipation of future federal dollars – these projects could inform decisions about how to spend new federal dollars." The Senate Health and Welfare Committee will hear testimony on this bill from ADAP.

Shifting to H.711, Senator Lyons noted that last year the Attorney General received a settlement which stipulated that an Opioid Settlement Advisory Council would be established. Rep Garafano then introduced H.711 to the committee and Legislative Council Katie McLinn walked through the bill. Vermont will receive $64 million over the next 18 years: 15% will go to municipalities to abate the opioid crisis, 15% will go to the State to remedy for past expenses or future expenses, and 70% will go to the statewide abatement fund. H.711 deals with the 70%, setting up an Advisory Council that makes recommendations to the Vermont Department of Health. Then, if there are future settlements, the State will use the same framework. The House Health Care Committee worked to find a balance in the composition of the Advisory Council between municipality representation and people with a statewide

perspective. The bill ensures that the Advisory Council will share its recommendations to the legislative committees of jurisdiction as well as VDH. The House Health Care Committee voted both bills out with an 11-0 vote, and a unanimous voice vote on the House Floor.

House Committee on Education Hears Testimony on Act 173

In preparation for the Legislative Committee on Administrative Rules (LCAR) review of rule changes to Act 173, the House Committee on Education heard testimony from the Census-Based Funding Advisory Group and other stakeholders.

Meagan Roy, Census-Based Funding Advisory Group Chair, reviewed the role of the group to advise the Vermont State Board of Education, and the extensive public comment opportunities offered throughout the state. Stakeholders focused on 2 key issues: ensuring enrollment practices for independent schools that accept public funds are non-discriminatory pertaining to disability and ensuring sufficient transparency around the rate-setting process for therapeutic schools. The group spent a large part of their time addressing concerns about the rule under section 2229 of Act 173, Approval to Receive Public Tuition, Special Education Approval, in that students on individual education plans (IEPs) would have access to appropriate services and not be denied access due to disability. The Advisory Group will continue to work with Local Education Agencies (LEA) to support student access to services.

Other witnesses testified to their support of the rule changes and positive experiences working with the Advisory Group. Mill Moore, Executive Director of the Vermont Independent Schools Association, noted they are fully supportive of the rules as adopted by the Board of Education and agree to the clarification of the role of independent schools. Jay Nichols, Executive Director of Vermont Principals' Association (VPA), shared that their main focus is “money in education should not allow for any discrimination”. Contrary to a public memo currently in circulation, the VPA supports tuition to independent schools under the newly revised rules. Jeffrey Francis, Executive Director of the Vermont Superintendents Association (VSA), agreed that the new rules reflect the intent of Act 173 and should proceed to the LCAR process.

Oliver Olsen, Chair of the Vermont State Board of Education, and Jennifer Samuelson, Vice Chair of the Vermont State Board of Education, are in full support of the changes and emphasized to the committee the efforts of the Advisory Group to be collaborative and hear constituent concerns. Not waiting for the 2023 effective date, the State Board of Education will put into effect the recommended anti-discrimination language as a condition of receiving public tuition dollars when it passes through LCAR.

Plan to Participate in these Advocacy Events

Save the Date! Vermont Disability Awareness Day

Join VCDR members and others from the disability community as we continue to present our legislative priorities and share our stories about important issues. In April the focus will be on housing. What are the challenges Vermonters with disabilities face in seeking, acquiring and maintaining secure homes? Join VCDR for a presentation of issues and discussion of solutions with people facing challenges and people working on solutions.

• Learn about what's happening today in housing issues as it relates to disabilities
• Hear people with disabilities and family members share their experiences and hopes around housing
• Join us and share your story!
This event will have ASL interpretation and live captioning. Register at: https://tinyurl.com/VCDRHousing4All
Contact vcdrvt@gmail.com or Nick at 802-224-1820 for information.

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.