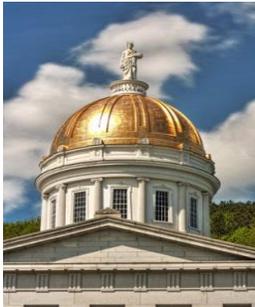




Supporting Vermonters to lead healthy and satisfying lives community by community

## Legislative Update for April 27, 2021



*The COVID 19 pandemic has changed the focus of Vermont Care Partners' advocacy efforts as our provider network has revamped our services to meet the needs Vermonters in new ways with careful precautions for health and safety of those we serve, our workforce and partners. Legislative work is being conducted remotely.*

### WHAT'S HAPPENING IN THE LEGISLATURE

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

*Vermont Care Partners and network agencies are advocating for resources to meet the increasing acuity and demand for services after the Governor's budget didn't address the rate increases needed for our workforce challenges.*

*The Vermont Care Partners legislative agenda is quite comprehensive and focuses on our need for adequate resources to meet our mission and mandates. See this link: <https://vermontcarepartners.org/wp-content/uploads/2021/01/legislative-agenda-2021-working-draft-1.pdf>*

### *This Week's Testimony*

### APPROPRIATIONS AND FUNDING-RELATED LEGISLATION

#### **Senate Appropriations Committee Finalizes FY22 Budget Proposal**

The Senate Health and Welfare is wrapping up its work on the FY22 Budget Bill. Vermont Care Partners is pleased to report that they included a 3% cost of living adjustment (COLA) for designated and specialized service agencies (DA/SSAs) mental health and developmental disabilities services. Additionally, the Committee amended the language on tuition assistance and loan repayment to read as follows:

Sec. E.311 AGENCY OF HUMAN SERVICES; DESIGNATED AND SPECIALIZED SERVICE AGENCIES; WORKFORCE DEVELOPMENT (a) The Agency of Human Services distribute the funds remaining from the \$5,000,000 appropriated to the Agency to make strategic investments in order to expand the supply of high-quality mental health and substance use disorder treatment professionals in 2018 (Sp. Sess.) Acts and Resolves No. 11, Sec 106.1 to the designated and specialized service agencies equitably based on each agency's proportion of full-time equivalent (FTE) mental health and substance use disorder treatment staff to the total number of FTE mental health and substance use disorder treatment staff across all designated and specialized service agencies statewide. The designated and specialized service agencies shall use these funds for loan repayment and tuition assistance to promote the recruitment and retention of high-quality mental health and substance use disorder treatment professionals available to Vermont residents in need of their services, as set forth in subsection (b) of this section. (b)(1) Each designated and specialized service agency shall make the funds received pursuant to subsection (a) of this section available to its current and prospective employees as set forth in subdivisions (A) and (B) of this subdivision (1) on a rolling basis in exchange for a one-year service obligation to provide mental health services or substance use disorder treatment services, or both, at a designated or specialized service agency in this State. The funds may be used for the following purposes: (A) loan repayment for master's-level clinicians, bachelor's-level direct service staff, and nurses; and (B) tuition assistance for individuals pursuing degrees to become master's-level clinicians, bachelor's-level direct service staff, and nurses(2) Loan repayment and tuition assistance funds shall be available to the current and prospective employees of designated and specialized service agencies in the form of forgivable loans, with the debt forgiven upon an employee's completion of the required service obligation. (c) Until the funds have been fully expended, the Agency of Human Services shall provide quarterly reports to the House Committees on Appropriations, on Health Care, and on Human Services, the Senate Committees on Appropriations and on Health and Welfare, and the Health Reform Oversight Committee with information on the following: (1) the specific designated and specialized service agencies that have received funds to date and the programs within each of those agencies in which the financial assistance recipients will deliver services; (2) the amount of financial assistance funding provided to each recipient; (3) the specific degrees or certificates toward which the tuition assistance recipients are working and those earned by loan repayment recipients; and (4) the number of new employees attracted to the designated and specialized service agencies as a result of the financial assistance, their fields of study, and the programs in which they deliver services.

The Senate Budget Language also includes this language clarifying the health care workforce strategic plan requirements.

Sec. E.300.1 2020 Acts and Resolves No. 155, Sec. 2 is amended to read: Sec. 2. HEALTH CARE WORKFORCE STRATEGIC PLAN; REPORT (a) The Director of Health Care Reform, in connection with the advisory group established pursuant to 18 V.S.A. § 9491(b) in Sec. 1 of this act, shall update the health care workforce strategic plan as set forth in 18 V.S.A. § 9491 and shall submit a draft of the plan to the Green Mountain Care Board for its review and approval on or before July 1 October 15, 2021. The Board shall review and approve the plan within 30 days following receipt. (b) On or before August 15 December 1, 2021, the Director shall provide the updated health care workforce strategic plan to the House Committees on Appropriations, on Health Care, and on Commerce and Economic Development and the Senate Committees on Appropriations, on Health and Welfare, and on Economic Development, Housing and General Affairs.

The next step is for presentation of the bill to the full Senate for approval. After the Senate approves the budget, it 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 is then 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 3<sup>rd</sup> week of May.

## **Senate Health and Welfare Makes Recommendation of the Budget**

In the Senate Health and Welfare Committee recommendation on the FY22 budget to the Senate Appropriations Committee they included language directing the University of Vermont and the Vermont State Colleges, in consultation with AHEC and VSAC, to explore ways to expand capacity in their health care professional education programs to increase the numbers of graduates entering Vermont's health care and social services workforce. This language does not appear to have been incorporated into the budget bill. Their proposed language reads as follows:

**Sec. X. HIGHER EDUCATION; UNIVERSITY OF VERMONT; VERMONT STATE COLLEGES; HEALTH CARE PROFESSIONAL PROGRAMS** (a) The University of Vermont and Vermont State Colleges, in consultation with the Office of Primary Care and Area Health Education Centers Program at the University of Vermont College of Medicine (AHEC) and the Vermont Student Assistance Corporation (VSAC), shall explore opportunities to expand capacity in their institutions' health care and social service professional education programs in order to increase the numbers of graduates entering Vermont's health care and social services workforce, particularly in nursing, primary care, psychiatry, and clinical mental health professions. (b) On or before January 15, 2022, the University of Vermont and Vermont State Colleges shall report their findings and recommendations, including proposals to address any identified barriers to expansion, to the House Committees on Health Care and on Education and the Senate Committees on Health and Welfare and on Education.

## **POLICY LEGISLATION**

### **Highlights of Final Work by Senate Health and Welfare on Health Reform Bills S.120 and S.132**

Jessica Barnard, Executive Director, Vermont Medical Society, testified that her association sees S.120 primarily aimed at exploring options for financing and expanding health care coverage while S.132 addresses Vermont's model of payment and delivery system. Jessica said reducing health care costs to improve access is a critical concern. They recommend that the S.120 task force focus on reducing cost growth, rather than on the all payer model (APM). The written testimony states, "VMS opposes the shift from the ACO to the GMCB in determining the amounts of value-based payments or shared savings that are distributed to ACO-participating providers". Susan Ridzon, Executive Director, HealthFirst, concurred with Jessica's testimony, but she wants to be sure there is an objective evaluation of the APM.

Betty Keller, M.D., President, The League of Women Voters, testified that the ACO adds an unnecessary bureaucratic organization in the health care system and would like to see it eliminated. The League does not want the APM to be renewed. She would rather see global budgets for all hospitals. Marvin Malek, M.D., Member, Vermont Physicians for a National Health Program, testified that cost control could be achieved with a national single all payer health care system. He said care coordination with mental health did not improve with OneCare, he credited the Blueprint for Health for those improvements.

Victoria Loner, RN.C, MHCDS, Chief Executive Officer, OneCare Vermont, said they are committed to health reform. The evaluation framework by NORC which is already in process is sufficient to achieve objectives outside of evaluation of the program. Additionally, she noted that the APM improvement plan, developed by the Agency of Human Services and approved by CMS, addresses this evaluation, as well. OneCare opposes much of S.132 because it moves ACO functions to a small office of state government which, in their opinion, does not have the capacity to do the work. Vicki does not see the value added of having the State Auditor review OneCare and sees the bill as adding administrative burden and unnecessary oversight.

Devon Green, Vice President of Government Relations, Vermont Association of Hospitals and Health Systems (VAHHS), testified that the language in S.132 sets up an environment of instability for health care providers. They do not support having the state auditor audit a non-government organization or moving health reform processes occurring at the GMCB to the Director of Health Reform in AHS as proposed in the Bill. VAHHS supports the goals of S.120, addressing the need for greater affordability of health care for Vermonters but they would rather work off previous efforts than have a new group study the issue, again. The APM and ACO is not about affordability, Devon explained, it is about improving quality of care, for instance urgent care for children in mental health crisis. Accountability can be addressed through the APM improvement plan. She sees ARPA as an opportunity to improve affordability for health care coverage. Some small employers could drop health care coverage because employees will be able to access insurance through the health care exchange at more affordable rates. She recommended looking more closely at finding more efficient ways of providing care coordination.

Steve Howard, Executive Director, Vermont State Employees Association, said they did not want their plan to go under OneCare, it was the Administration's decision. They would like to see a focus on increasing primary care and would like organized labor to be at the table for health reform discussions.

Helen Labun, Director, Vermont Public Policy, Bi-State Primary Care Association, spoke broadly on health and payment reform. She pointed out that FQHCs must follow the requirements of federal government and the APM and its value-based payment is important to the federal government. Michael Costa, CEO, North Counties Health Care, said the transition to value-based care "requires time, trust and effective risk-management". He said if health care reform direction is uncertain going forward, it has a chilling effect on the choices and investments by health providers.

The insurers, BC/BS and MVP testified that they support a study about covering hearing aids. Senator Cummings is concerned about adding costs to the state employees' and teachers' insurance coverage.

In the end the Committee placed some sections of H.132 into H.120. They renamed the H.120 Commission, Taskforce on Affordable Health Care because of its short-term and specific focus. The taskforce is asked to utilize the health reform principles in Title 18, which was passed as Act 48 and which has since been updated. Senator Lyons want the Taskforce to take input from Vermonters through listening sessions. There was some debate in the community about specific language regarding public listening sessions by the taskforce. Senators Hardy and Hooker wanted the Taskforce to seek specific feedback on the ACO and other health providers. Senator Lyons insisted, with support from Senator Cummings, that the language be broader and simply ask Vermont residents and businesses about how they view the health care system, including access to affordability. In the end the more general language was used.

### **Senate Health and Welfare Take Further Testimony and Finalizes Health Equities Bill H.210**

Kathy Fulton, Executive Director, VPQHC, requested consistent funding for health equity training series for health professionals conducted by her organization. Wichie Artu, Vice President, NAACP - Windham County, expressed concerned about the sustainability of funding for collaborative partnerships and the future office of health equity. Senator Hardy assured him that the new draft of the bill sets a date certain for the establishment of the office. Joanne Crawford, Member, Abenaki Nation, would like more health data on native Americans. Mark Hughes, Executive Director, Vermont Racial Justice Alliance, testified that even though his group developed the first draft of H.210, in its current form they cannot support it.

Kirsten Murphy, Executive Director, Vermont Developmental Disabilities Council and Max Barrows, Outreach Director, Green Mountain Self Advocates testified together. Kirsten said the disabilities community shares a common legacy with BIPOC and LGBTQ communities whose health inequities are rooted in historic injustices. She highlighted that disabilities impact one in five Americans, making people with disabilities the largest group experiencing health disparities. Max shared some of the barriers to accessing quality health care experiences by people with disabilities:

1. Information presented by health professionals is difficult to understand – written information would be helpful;
2. Health professionals need training on how to work with people with disabilities;
3. It is difficult to use programs designed by public health because they are not accessible; and
4. There are not enough therapists working with people with disabilities.

Kirsten shared the results of the SIM grant which were consistent with Max's remarks. The study found that people with disabilities have health disparities because of:

- the lack of provider training;
- health information is not presented in cognitively accessible ways;
- not enough time for appointments to address individual needs;
- lack of physical access;
- referrals and screening aren't conducted on the same regular basis as for other people; and
- sexually related health care is not offered or provided appropriately.

The Developmental Disabilities Council agreed with previous testimony about changing the definition of people experiencing health disparities based on race to avoid referencing not being white. Given their extensive work on health disparities experienced by people with disabilities, Kirstin requested naming the Developmental Disabilities Council for membership on the Advisory Council.

Kiah Morris, Movement Politics Director, Rights and Democracy Vermont, testified in favor of the bill. She is a bit concerned about the timeframe being too short to develop the trust and thought necessary for the advisory committee to do its work. She also wondered about how the public will learn about the office of health equity and its work as it is developed.

Katie McLinn worked with the Committee on a strike all amendment to the bill. They will add a finding on Abnaki people and a finding about eugenics quoting the House Resolution passed earlier in the session. The language speaks to analyzing terms and definitions of racial categories and adds a definition for cultural humility. The Advisory Commission membership will now include the Developmental Disability Council. The Office of the Health Equity is given a specific date for its establishment, January 2023. The Committee approved the Bill on a vote of 5-0-0.

### **House Health Care Studies Children Waiting in Emergency Departments**

On April 22, House Health Care heard testimony on the problem of children waiting in Emergency Departments for inpatient care. Chair Lippert defined the question that the hearing is intended to answer: "what is it that we would need to do to never have a child in the Emergency Department waiting for treatment?"

DMH Child, Adolescent and Family Unit Chief Laurel Omland shared data showing increased mental health challenges and increased utilization of emergency departments and length of stay for teens ages 11 to 17. CAFU Medical Director David Rettew described the current crisis as a perfect storm, given

the pent-up isolation and anxiety from COVID-19, as well as a seasonal component having to do with the end of the school year. He noted that data from Australia shows the opposite trends in the Southern hemisphere. Omland noted that community mental health service provision has been impacted by COVID, including use of telehealth instead of in person treatment and workforce pressures. Omland also testified that staffing challenges as well as COVID spacing needs have closed beds at the Brattleboro Retreat and at NFI. She said DMH is exploring what is needed to enhance the continuum of care, and that DMH wants to target federal funding in a strategic manner. The DMH presentation is [here](#).

The committee also heard from Christian Pulcini, a Pediatric Emergency Medicine Doctor at UVM, and Alison Kapadia and Kat McGraw, doctors with Brattleboro Memorial Hospital. All spoke of the increasing demand for mental health treatment and that the Emergency Department is not the right place to receive or wait for this care. Pulcini reported a three-fold increase in mental health concerns at their Emergency Department [ED] between 2010-2019. He shared that at his previous job in Pennsylvania, the hospital had to build six mental health beds when a nearby crisis center closed. He shared that, statewide, hospitals are exploring the possibility of admitting children onto the pediatric floor.

Kapadia is interested in something like a PUCK model in her region. She was asked about what community resources she interacts with. She responded that “HCRS, our designated agency, is always involved; often DCF is involved; other services through HCRS that are not Emergency Services (such as Children’s Services); DMH case management, and telepsychiatry.” She shared that they try to ensure that HCRS can provide services over Zoom to kids waiting in EDs for continuity of care. She noted that for younger children, most are already connected to services, but for teens, the ED can often be their first interaction with the mental health system.

Devon Green from the Vermont Association of Hospitals and Health Systems [VAHHS] testified that VAHHS sees this issue as a public health emergency. She shared [point-in-time data](#) on volume of youth currently and recently waiting in Emergency Departments. VAHHS sees a need for resources for data collection and analysis, including a workable bed board. Green stated, “We need resources at every level of care. We need a PUCK in the south. We need one in the North. Half of the [Brattleboro Retreat] adolescent unit could discharge if they had stepdown resources.” Green also identified regulatory flexibilities and Emergency Certificate of Need Processes to retrofit EDs as emergency response tools that could be helpful and identified “ED wait times” as an outcome that should be attached to every healthcare initiatives. Noting that VAHHS had recently met with advocates to discuss alternatives to EDs, she believes there should be alignment on measures to unify and fix system flow issues.

Dillon Burns, Director of Mental Health Services, VCP and Lorna Mattern, Executive Director, United Counseling Services [testified](#) on behalf of our system of care. Burns showed increasing trends in Vermonters served in Emergency Services (children and adults) and shared information about Children, Youth, and Family Services. She highlighted how need is currently outstripping capacity, citing long waitlists and staffing vacancies in the VCP network, with few applicants. A robust community-based service package could effectively meet many of the needs of the children and youth waiting in emergency departments. The State needs to address the erosion of the community-based system due to years of underfunding through a) an initial investment, possibly using COVID relief dollars, followed by b) a commitment to ensure the sustainability of the system. She also advocated for investment in crisis diversion programs, including NFI North/South, Jarrett House, the Mobile Response Pilot Proposal in Rutland, and PUCK.

Mattern testified on the success of the PUCK model. She described the agency’s process of community engagement in the design of the model, and shared a day at PUCK, in which children and youth receive

self-regulation supports, crisis planning, medication consultation, and referral. Kids go home over night but can return to PUCK on the following day or for planned respite. Mattern demonstrated a 33% reduction in kids screened in the ED since PUCK opened, and demonstrated shorter overall wait times for kids who were in the ED. In response to questions about funding, she shared that UCS is currently carrying the cost of the program through the DMH case rate, since OneCare funding ended.

Finally, the committee heard from parents Robyn Freedner-Maguire, Andy Anderson, and Kathleen Kournebanas. Freedner-Maguire stated that she would like to see more attention on crisis services. She described some challenging and traumatic experiences her child dealt with in the ED. She would like to see “appropriate transportation to the appropriate location, for appropriate treatment.” Anderson reported that his child never wants to access medical care again after a terrible ED experience. Kournebanas focused on system issues. Citing that her daughter has severe Autism Spectrum Disorder, she said she was “frustrated that AHS (Agency of Human Services) is not here [because] it’s all part of the same system of care.” She thinks it is important to understand how many kids waiting have I/DD challenges and how many are neurotypical. She was told her daughter needed to wait in the ED when that was not the case and feels that other kids may be in the same boat. She feels that AHS is not held accountable through the Act 264 process and is filing an Olmstead violation with the State.

As the hearing closed, Representative Goldman stated, “I would like to bring up disparities of pay for staff at DAs versus schools.” Chair Lippert responded: “We won’t lose sight of that with me as chair. This committee has been a strong advocate for that. Members have been steadfast for adequate funding and staffing for our community system.”

### **Medicaid 101 and Global Commitment in House Appropriations ([link](#))**

On April 22, House Appropriations used “down time” while the Senate works on the state budget to educate themselves on Vermont Medicaid systems. Nolan Langweil from the Joint Fiscal Office provided an overview presentation on Medicaid: [Health Care Finance 101 \(New Member Orientation\) \(vermont.gov\)](#)

Langweil noted that one third of Vermonters receive some form of assistance through Medicaid, with 22% having Medicaid as primary insurance (in line with the national average). Vermont spends about \$220 million each year on people who are dually eligible for Medicaid and Medicare (approximately 17-18,000 people). Of the 3.2% of Vermonters who are uninsured, 17% of those people are eligible for Medicaid and 43% are eligible for at least some state and/or federal subsidies. Overall, \$6.26 billion is spent each year on health care for Vermonters, with \$1.38 billion spent in FY20 for Medicaid alone. Representative Yacavone asked: “we often hear that reimbursement rates are inadequate – does the State have limitations?” Langweil responded that yes, there are limitations that are tied to Medicare rates. He shared information about how the federal match rate is calculated. Vermont’s rate is 54.57 but we are receiving an additional 6.2% FMAP bump, bringing in an additional \$20 million per quarter. How do we fund the state portion of Medicaid? 42% of state Medicaid comes from the general fund; other sources include cigarette taxes, employer assessment, claims assessment, and provider taxes. Hospitals contribute about \$150 million per year in provider taxes. Committee members found this confusing. Langweil shared that we “tax the system to draw down federal match to put back into the system.”

DVHA Commissioner Cory Gustafson, Director of Health Reform Ena Backus, and AHS CFO Sarah Clark then provided the committee with a [presentation](#) on the Global Commitment Waiver.

Gustafson noted that the Global Commitment [GC] Waiver, which the state has had since 2005, is up for renewal. One challenge is that “the feds don’t know exactly how to treat Vermont.” Most states contract with a managed care organization. “In Vermont, we don’t have that,” he said. “We have a public MCO [DVHA].” He noted that negotiations on the next waiver have not begun yet. Representative Yacavone noted that there is a high recidivism rate in Corrections. He wondered if the GC Waiver could cover case management for this population. Gustafson responded that AHS is having conversations about how to improve communication prior to release. Gustafson was also pressed on how to support the health and wellbeing of homeless populations.

In summarizing the 1115 Waiver, Gustafson shared that the 1115 Waiver currently covers:

- Vermont Premium Assistance (up to 300% FPL who purchase coverage through exchange)
- Community Rehabilitation and Treatment (138-185% FPL)
- VPharm Pharmacy Assistance (for Medicare beneficiaries up to 225% FPL)
- Choices for Care Moderate Needs Group (up to 300% FPL)
- IMD payments (VPCH and Brattleboro Retreat)
- Children’s palliative care service
- Investments

He shared that Vermont is a leader in innovative models, using CRT programs as an example, and “we emphasize our leadership and innovation as a state when we meet with federal partners.” Technical advisors to DVHA have encouraged them to “get in now” and get to an agreement as soon as possible. Sarah Clark explained to the committee that part of the waiver is “Budget Neutrality” -- not spending more with the waiver than what you would without the waiver.” Each year, the agency has made shifts to maintain budget neutrality, including moving Institute for Mental Disease and ADAP spending out of the waiver, into other programs.

Representative Yacavone asked about dual eligible Vermonters. “Are there things we are hoping to propose in the waiver negotiations that will help them?” He noted that in Choices for Care, the State was able to demonstrate cost savings. “Are there opportunities to strengthen the providers who serve elder and disabled Vermonters, to reduce expenditures in other services?” DHVA did not provide details on their proposal because they are in negotiations, but Backus emphasized that they are prioritizing flexibility in the application.

Ena Backus, Director of Health Reform, shared that the federal government has placed limits on AHS and DVHA that MCOs in other states do not have. The State wants to fully leverage the MCO flexibilities. AHS is approaching this renewal with these goals: access to care; innovative healthcare models; engaging in transforming health; and accelerating healthcare reform. They plan to request that the State regain IMD expenditure authority, which would allow reimbursement for stays to exceed 60 days, forensic populations, and Lund; prioritize robust assistance for homeless populations with high needs; and request MCO-level flexibilities. They hope to have the new waiver in place by January 1, 2022.

Chair Hooper asked how they are engaging stakeholders. Gustafson said the State is receiving input from the Medicaid Exchange Advisory Board and there will be a state and federal public comment process for the waiver. Committee members pressed DVHA on their coordination with DCF regarding homeless Vermonters. Hooper noted that the mental health and substance use disorder needs of the homeless population are not well-coordinated, similarly, the forensic population may not be getting the services they need when they transition back to the community. Backus responded that the Secretary’s office runs a housing taskforce across AHS.

Backus also responded to questions about AHS's implementation improvement plan for OneCare. She noted that there has been progress. When Representative Yacavone asked "what further can Vermont do to expand/accelerate fixed rate payments?" Backus said that our agreement does not require fixed payments, which are considered the most advanced. "Vermont is one of two states with alternative payment models. \$1 billion has been converted to value-based payments where there is two-sided risk: providers share in savings, but also in risk. We need to move towards more fixed prospective payments. We need to work towards that with commercial payors."

### **Facilitation of Interstate Practice Using Telehealth Workgroup in Senate Health and Welfare**

On Friday, April 23, Senate Health and Welfare passed H. 104 out of committee. The bill creates a workgroup, chaired by the Office of Professional Regulation, that would examine telehealth licensure issues and opportunities including national compacts, regional reciprocity, and potential impacts and ethical considerations for Vermonters, with a legislative report due December 15, 2021. The workgroup will include representation from provider organizations in the state. The committee passed an amendment to add the Commissioner of Mental Health or designee to the Workgroup. H.104 will now go to the full Senate for consideration.

### **Senate Government Operations Committee Considers Eugenics Resolution**

Senate Government Operations committee heard initial testimony on JRH2 which was passed by the House 2 weeks ago. The joint resolution sincerely apologizes and expresses sorrow and regret to all individual Vermonters and their families and descendants who were harmed as a result of State-sanctioned eugenics policies and practices.

Representative Tom Stevens, Chair of House General and Military gave a summary of the actions in his committee. He reminded the committee that this resolution is the first time the State of Vermont has formally apologized for state-sanctioned policies. The resolution passed through his committee on a 11-0 vote and passed the House with a 146-0 vote.

Senator White clarified that if Senate Government Operations makes any changes to the Resolution, it essentially is treated just as a bill would be treated and would go back to House General and Military for concurrence or a committee of conference. Since it is a Joint Resolution, however, it does not go to the Governor for signature. Senator Ram wondered why the Resolution did not speak to the impact on women and people with disabilities more than it does. Representative Stevens replied that they felt what they had written was inclusive of those groups, but that in speaking with members of the disability community, in terms of being referenced more in the resolution, "it didn't come up as a need for them." He did not mention the testimony from Susan Aranoff of the Developmental Disabilities Council that spoke specifically to the continuing impact of the eugenics movement on people with disabilities. The committee discussed whether a resolution can apologize for actions of others (state agencies, UVM, etc.) or whether, since it is a joint resolution of the House and Senate, it can only speak to actions that the Legislature took. It appeared that this will be a large part of what the committee will discuss about the resolution in the coming weeks.

The Committee heard testimony from Judy Dow, author of a book about eugenics and Carol McGranaghan, Chair, Vermont Commission on Native American Affairs, who presented testimony they had given to the House. They also heard from Tanya Marshall, the State Archivist who shared what records are in the State Archives that could be of use to the Committee if they so desired. Senator White said she hoped to hear more testimony on this resolution, possibly this coming Friday.

### ***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.