S.126

An act relating to health care payment and delivery system reform

The House proposes to the Senate to amend the bill by striking out all after the enacting clause and inserting in lieu thereof the following:

* * * Purpose of the Act; Goals * * *

Sec. 1. PURPOSE; GOALS

The purpose of this act is to achieve transformation of and structural changes to Vermont's health care system. In enacting this legislation, the General Assembly intends to advance the following goals:

(1) improvements in health outcomes, population health, quality of care, regional access to services, and reducing disparities in access resulting from demographic factors or health status;

(2) an integrated system of care, with robust care coordination and increased investments in primary care, home health care, and long-term care;

(3) stabilizing health care providers, controlling the costs of commercial health insurance, and managing hospital costs based on the total cost of care, beginning with reference-based pricing;

(4) evaluating progress in achieving system transformation and structural changes by creating and applying standardized accountability metrics; and

(5) establishing a health care system that will attract and retain high-quality health care professionals to practice in Vermont and that supports, develops, and preserves the dignity of Vermont's health care workforce.

* * * Hospital Budgets and Payment Reform * * *

Sec. 2. 18 V.S.A. § 9375 is amended to read:

§ 9375. DUTIES

(a) The Board shall execute its duties consistent with the principles expressed in section 9371 of this title.

(b) The Board shall have the following duties:

(1) Oversee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs; promote seamless care, administration, and service delivery; and maintain health care quality in Vermont, including ensuring that the payment reform pilot projects set forth in this chapter are consistent with such reforms.

(A) Implement by rule, pursuant to 3 V.S.A. chapter 25, methodologies for achieving payment reform and containing costs that may include the participation of Medicare and Medicaid, which may include the creation of health care professional cost-containment targets, reference-based pricing, global payments, bundled payments, global budgets, risk-adjusted capitated payments, or other uniform payment methods and amounts for

integrated delivery systems, health care professionals, or other provider arrangements.

* * *

(5) Set rates for health care professionals pursuant to section 9376 of this title, to be implemented over time beginning with reference-based pricing as soon as practicable, but not later than hospital fiscal year 2027, and make adjustments to the rules on reimbursement methodologies as needed.

(6) Approve, modify, or disapprove requests for health insurance rates pursuant to 8 V.S.A. § 4062, taking into consideration the requirements in the underlying statutes~~,~~; changes in health care delivery~~,~~; changes in payment methods and amounts, including implementation of reference-based pricing; protecting insurer solvency~~,~~; and other issues at the discretion of the Board.

(7) Review and establish hospital budgets pursuant to chapter 221, subchapter 7 of this title.

* * *

Sec. 3. 18 V.S.A. § 9376 is amended to read:

§ 9376. PAYMENT AMOUNTS; METHODS

(a) Intent. It is the intent of the General Assembly to ensure payments to health care professionals that are consistent with efficiency, economy, and quality of care and will permit them to provide, on a solvent basis, effective and efficient health services that are in the public interest. It is also the intent

of the General Assembly to eliminate the shift of costs between the payers of health services to ensure that the amount paid to health care professionals is sufficient to enlist enough providers to ensure that health services are available to all Vermonters and are distributed equitably.

(b) Rate-setting.

(1) The Board shall set reasonable rates for health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies based on methodologies pursuant to section 9375 of this title, in order to have a consistent reimbursement amount accepted by these persons. In its discretion, the Board may implement rate-setting for different groups of health care professionals over time and need not set rates for all types of health care professionals. In establishing rates, the Board may consider legitimate differences in costs among health care professionals, such as the cost of providing a specific necessary service or services that may not be available elsewhere in the State, and the need for health care professionals in particular areas of the State, particularly in underserved geographic or practice shortage areas.

(2) Nothing in this subsection shall be construed to:

(A) limit the ability of a health care professional to accept less than the rate established in subdivision (1) of this subsection (b) from a patient without health insurance or other coverage for the service or services received; or

(B) reduce or limit the covered services offered by Medicare or Medicaid.

(c) Methodologies. The Board shall approve payment methodologies that encourage cost-containment; provision of high-quality, evidence-based health services in an integrated setting; patient self-management; access to primary care health services ~~for underserved individuals, populations, and areas~~; and healthy lifestyles. Such methodologies shall be consistent with payment reform and with evidence-based practices, and may include fee-for-service payments if the Board determines such payments to be appropriate.

(d) Supervision. To the extent required to avoid federal antitrust violations and in furtherance of the policy identified in subsection (a) of this section, the Board shall facilitate and supervise the participation of health care professionals and health care provider bargaining groups in the process described in subsection (b) of this section.

(e) Reference-based pricing.

(1)(A) The Board shall establish reference-based prices that represent the maximum amounts that hospitals shall accept as payment in full for items provided and services delivered in Vermont. The Board may also implement reference-based pricing for services delivered outside a hospital by setting the minimum amounts that shall be paid for items provided and services delivered by nonhospital-based health care professionals. The Board shall consult with health insurers, hospitals, other health care professionals as applicable, the Office of the Health Care Advocate, and the Agency of Human Services in developing reference-based prices pursuant to this subsection (e), including on ways to achieve all-payer alignment on the design and implementation of reference-based pricing.

(B) The Board shall implement reference-based pricing in a manner that does not allow health care professionals to charge or collect from patients or health insurers any amount in excess of the reference-based amount established by the Board.

(2)(A) Reference-based prices established pursuant to this subsection (e) shall be based on a percentage of the Medicare reimbursement for the same or a similar item or service or on another benchmark, as appropriate, provided that if the Board establishes prices that are referenced to Medicare, the Board may opt to update the prices in the future based on a reasonable rate of growth that is separate from Medicare rates, such as the Medicare Economic Index

measure of inflation, in order to provide predictability and consistency for health care professionals and payers and to protect against federal funding pressures that may impact Medicare rates in an unpredictable manner. The Board may also reference to, and update based on, other payment or pricing systems where appropriate.

(B) In establishing reference-based prices for a hospital pursuant to this subsection (e), the Board shall consider the composition of the communities served by the hospital, including the health of the population, demographic characteristics, acuity, payer mix, labor costs, social risk factors, and other factors that may affect the costs of providing care in the hospital service area, as well as the hospital's role in Vermont's health care system.

(3)(A) The Board shall begin implementing reference-based pricing as soon as practicable but not later than hospital fiscal year 2027 by establishing the maximum amounts that Vermont hospitals shall accept as payment in full for items provided and services delivered. After initial implementation, the Board shall review the reference-based prices for each hospital annually as part of the hospital budget review process set forth in chapter 221, subchapter 7 of this title.

(B) The Board, in collaboration with the Department of Financial Regulation, shall monitor the implementation of reference-based pricing to ensure that any decreases in amounts paid to hospitals also result in decreases

in health insurance premiums. The Board shall post its findings regarding the alignment between price decreases and premium decreases annually on its website.

(4) The Board shall identify factors that would necessitate terminating or modifying the use of reference-based pricing in one or more hospitals, such as a measurable reduction in access to or quality of care.

(5) The Green Mountain Care Board, in consultation with the Agency of Human Services and the Comprehensive Primary Health Care Steering Committee established pursuant to section 9407 of this title, may implement reference-based pricing for services delivered outside a hospital, such as primary care services, and may increase or decrease the percentage of Medicare or another benchmark as appropriate, first to enhance access to primary care and later for alignment with the Statewide Health Care Delivery Strategic Plan established pursuant to section 9403 of this title, once established. The Board may consider establishing reference-based pricing for services delivered outside a hospital by setting minimum amounts that shall be paid for the purpose of prioritizing access to high-quality health care services in settings that are appropriate to patients' needs in order to contain costs and improve patient outcomes.

(6) The Board's authority to establish reference-based prices pursuant to this subsection shall not include the authority to set amounts applicable to

items provided or services delivered to patients who are enrolled in Medicare or Medicaid.

Sec. 3a. 18 V.S.A. § 9451 is amended to read:

§ 9451. DEFINITIONS

As used in this subchapter:

(1) "Hospital" means a hospital licensed under chapter 43 of this title, except a hospital that is conducted, maintained, or operated by the State of Vermont.

(2) "Hospital network" means a system comprising two or more affiliated hospitals, and may include other health care professionals and facilities, that derives 50 percent or more of its operating revenue, at the consolidated network level, from Vermont hospitals and in which the affiliated hospitals deliver health care services in a coordinated manner using an integrated financial and governance structure.

(3) "Volume" means the number of inpatient days of care or admissions and the number of all inpatient and outpatient ancillary services rendered to patients by a hospital.

Sec. 4. 18 V.S.A. § 9454 is amended to read:

§ 9454. HOSPITALS; DUTIES

* * *

(b) Hospitals shall submit information as directed by the Board in order to maximize hospital budget data standardization and allow the Board to make direct comparisons of hospital expenses across the health care system.

(c) Hospitals shall adopt a fiscal year that shall begin on October 1.

Sec. 5. 18 V.S.A. § 9456 is amended to read:

§ 9456. BUDGET REVIEW

(a) The Board shall conduct reviews of each hospital's proposed budget based on the information provided pursuant to this subchapter and in accordance with a schedule established by the Board.

(b) In conjunction with budget reviews, the Board shall:

(1) review utilization information;

(2) consider the Statewide Health Care Delivery Strategic Plan developed pursuant to section 9403 of this title, once established, including the total cost of care targets, and consult with the Agency of Human Services to ensure compliance with federal requirements regarding Medicare and Medicaid;

(3) consider the Health Resource Allocation Plan identifying Vermont's critical health needs, goods, services, and resources developed pursuant to section 9405 of this title;

~~(3)~~(4) consider the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review;

~~(4)~~(5) consider any reports from professional review organizations;

(6) for a hospital that operates within a hospital network, review the hospital network's financial operations as they relate to the budget of the individual hospital;

~~(5)~~(7) solicit public comment on all aspects of hospital costs and use and on the budgets proposed by individual hospitals;

~~(6)~~(8) meet with hospitals to review and discuss hospital budgets for the forthcoming fiscal year;

~~(7)~~(9) give public notice of the meetings with hospitals~~,~~ and invite the public to attend and to comment on the proposed budgets;

~~(8)~~(10) consider the extent to which costs incurred by the hospital in connection with services provided to Medicaid beneficiaries are being charged to non-Medicaid health benefit plans and other non-Medicaid payers;

~~(9)~~(11) require each hospital to file an analysis that reflects a reduction in net revenue needs from non-Medicaid payers equal to any anticipated increase in Medicaid, Medicare, or another public health care program

reimbursements, and to any reduction in bad debt or charity care due to an increase in the number of insured individuals;

~~(10)~~(12) require each hospital to provide information on administrative costs, as defined by the Board, including specific information on the amounts spent on marketing and advertising costs;

~~(11)~~(13) require each hospital to create or maintain connectivity to the State's Health Information Exchange Network in accordance with the criteria established by the Vermont Information Technology Leaders, Inc., pursuant to subsection 9352(i) of this title, provided that the Board shall not require a hospital to create a level of connectivity that the State's Exchange is unable to support;

~~(12)~~(14) review the hospital's investments in workforce development initiatives, including nursing workforce pipeline collaborations with nursing schools and compensation and other support for nurse preceptors; ~~and~~

~~(13)~~(15) consider the salaries for the hospital's executive and clinical leadership, including variable payments and incentive plans, and the hospital's salary spread, including a comparison of median salaries to the medians of northern New England states and a comparison of the base salaries and total compensation for the hospital's executive and clinical leadership with those of the hospital's lowest-paid employees who deliver health care services directly to hospital patients; and

(16) consider the number of employees of the hospital whose duties are primarily administrative in nature, as defined by the Board, compared with the number of employees whose duties primarily involve delivering health care services directly to hospital patients.

(c) Individual hospital budgets established under this section shall:

(1) be consistent, to the extent practicable, with the Statewide Health Care Delivery Strategic Plan, once established, including the total cost of care targets, and with the Health Resource Allocation Plan;

(2) reflect the reference-based prices established by the Board pursuant to section 9376 of this title;

(3) take into consideration national, regional, or in-state peer group norms, according to indicators, ratios, and statistics established by the Board;

~~(3)~~(4) promote efficient and economic operation of the hospital and, if a hospital is affiliated with a hospital network, ensure that hospital spending on the hospital network's operations is consistent with the principles for health care reform expressed in section 9371 of this title and with the Statewide Health Care Delivery Strategic Plan, once established;

~~(4)~~(5) reflect budget performances for prior years;

~~(5)~~(6) include a finding that the analysis provided in subdivision ~~(b)(9)~~ (b)(11) of this section is a reasonable methodology for reflecting a reduction in net revenues for non-Medicaid payers; ~~and~~

~~(6)~~(7) demonstrate that they support equal access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care as part of an integrated, holistic system of care; and

(8) include meaningful variable payments and incentive plans for hospitals that are consistent with this section and with the principles for health care reform expressed in section 9371 of this title.

(d)(1) Annually, the Board shall establish a budget for each hospital on or before September 15, followed by a written decision by October 1. Each hospital shall operate within the budget established under this section.

* * *

(e)(1) The Board, in consultation with the Vermont Program for Quality in Health Care, shall utilize mechanisms to measure hospital costs, quality, and access and alignment with the Statewide Health Care Delivery Strategic Plan, once established.

(2)(A) Except as provided in subdivision (D) of this subdivision (e)(2), a hospital that proposes to reduce or eliminate any service in order to comply with a budget established under this section shall provide a notice of intent to the Board, the Agency of Human Services, the Office of the Health Care Advocate, and the members of the General Assembly who represent the

hospital service area not less than 45 days prior to the proposed reduction or elimination.

(B) The notice shall explain the rationale for the proposed reduction or elimination and describe how it is consistent with the Statewide Health Care Delivery Strategic Plan, once established, and the hospital's most recent community health needs assessment conducted pursuant to section 9405a of this title and 26 U.S.C. § 501(r)(3).

(C) The Board may evaluate the proposed reduction or elimination for consistency with the Statewide Health Care Delivery Strategic Plan, once established and the community health needs assessment, and may modify the hospital's budget or take such additional actions as the Board deems appropriate to preserve access to necessary services.

(D) A service that has been identified for reduction or elimination in connection with the transformation efforts undertaken by the Board and the Agency of Human Services pursuant to 2022 Acts and Resolves No. 167 does not need to comply with subdivisions (A)–(C) of this subdivision (e)(2).

(3) The Board, in collaboration with the Department of Financial Regulation, shall monitor the implementation of any authorized decrease in hospital services to determine its benefits to Vermonters or to Vermont's health care system, or both.

(4) The Board may establish a process to define, on an annual basis, criteria for hospitals to meet, such as utilization and inflation benchmarks.

(5) The Board may waive one or more of the review processes listed in subsection (b) of this section.

* * *

Sec. 6. 18 V.S.A. § 9458 is added to read:

§ 9458. HOSPITAL NETWORKS; STRUCTURE; FINANCIAL OPERATIONS

(a) The Board may review and evaluate the structure of a hospital network to determine:

(1) whether any network operations should be organized and operated out of a hospital instead of at the network; and

(2) whether the existence and operation of a network provides value to Vermonters, is in the public interest, and is consistent with the principles for health care reform expressed in section 9371 of this title and with the Statewide Health Care Delivery Strategic Plan, once established.

(b) In order to protect the public interest, the Board may, on its own initiative, investigate the financial operations of a hospital network, including compensation of the network's employees and executive leadership.

(c) The Board may recommend any action it deems necessary to correct any aspect of the structure of a hospital network or its financial operations that

are inconsistent with the principles for health care reform expressed in section 9371 of this title or with the Statewide Health Care Delivery Strategic Plan, once established.

* * * Health Care Contracts * * *

Sec. 7. 18 V.S.A. § 9418c is amended to read:

§ 9418c. FAIR CONTRACT STANDARDS

* * *

(e)(1) The requirements of subdivision (b)(5) of this section do not prohibit a contracting entity from requiring a reasonable confidentiality agreement between the provider and the contracting entity regarding the terms of the proposed health care contract.

(2) Upon request, a contracting entity or provider shall provide an unredacted copy of an executed or proposed health care contract to the Department of Financial Regulation or the Green Mountain Care Board, or both.

* * * Statewide Health Care Delivery Strategic Plan; Health Care Delivery Advisory Committee; Comprehensive Primary Health Care Steering Committee * * *

Sec. 8. 18 V.S.A. § 9403 is added to read:

§ 9403. STATEWIDE HEALTH CARE DELIVERY STRATEGIC PLAN

(a) The Agency of Human Services, in collaboration with the Green Mountain Care Board, the Department of Financial Regulation, the Vermont Program for Quality in Health Care, the Office of the Health Care Advocate, the Health Care Delivery Advisory Committee established in section 9403a of this title, the Comprehensive Primary Health Care Steering Committee established pursuant to section 9407 of this title, and other interested stakeholders, shall lead development of an integrated Statewide Health Care Delivery Strategic Plan as set forth in this section.

(b) The Plan shall:

(1) Align with the principles for health care reform expressed in section 9371 of this title.

(2) Identify existing services and promote universal access across Vermont to high-quality, cost-effective acute care; primary care, including primary mental health services; chronic care; long-term care; substance use disorder treatment services; emergency medical services; nonemergency medical services; nonmedical services and supports; and hospital-based, independent, and community-based services.

(3) Define a shared vision and shared goals and objectives for improving access to and the quality, efficiency, and affordability of health care services in

Vermont and for reducing disparities in access resulting from demographic factors or health status, including benchmarks for evaluating progress.

(4) Identify the resources, infrastructure, and support needed to achieve established targets, which will ensure the feasibility and sustainability of implementation.

(5) Provide a phased implementation timeline with milestones and regular reporting to ensure adaptability as needs evolve.

(6) Promote accountability and continuous quality improvement across Vermont's health care system through the use of data, scientifically grounded methods, and high-quality performance metrics to evaluate effectiveness and inform decision making.

(7) Provide annual targets for the total cost of care across Vermont's health care system. Using these total cost of care targets, the Plan shall identify appropriate allocations of health care resources and services across the State that balance quality, access, and cost containment. The Plan shall also establish targets for the percentages of overall health care spending that should reflect spending on primary care services, including mental health services, and on preventive care services, which targets shall be aligned with the total cost of care targets.

(8) Build on data and information from:

(A) the transformation planning resulting from 2022 Acts and Resolves No. 167, Secs. 1 and 2;

(B) the expenditure analysis and health care spending estimate developed pursuant to section 9383 of this title;

(C) the State Health Improvement Plan adopted pursuant to subsection 9405(a) of this title;

(D) the Health Resource Allocation Plan published by the Green Mountain Care Board in accordance with subsection 9405(b) of this title;

(E) hospitals' community health needs assessments and strategic planning conducted in accordance with section 9405a of this title;

(F) hospital and ambulatory surgical center quality information published by the Department of Health pursuant to section 9405b of this title;

(G) the statewide quality assurance program maintained by the Vermont Program for Quality in Health Care pursuant to section 9416 of this title;

(H) the 2020 report determining the proportion of health care spending in Vermont that is allocated to primary care, submitted to the General Assembly by the Green Mountain Care Board and the Department of Vermont Health Access in accordance with 2019 Acts and Resolves No. 17, Sec. 2;

(I) the 2024 report on Blueprint for Health payments to patient-centered medical homes, submitted to the General Assembly by the Agency of

Human Services in accordance with 2023 Acts and Resolves No. 51, Sec. 5; and

(J) such additional sources of data and information as the Agency and other stakeholders deem appropriate.

(9) Identify:

(A) opportunities to improve the quality of care across the health care delivery system, including exemplars of high-quality care to stimulate best practice dissemination;

(B) gaps in access to care, as well as unnecessary duplication of services, including circumstances in which service closures or consolidations may result in improvements in quality, access, and affordability;

(C) opportunities to reduce administrative burdens;

(D) federal, State, and other barriers to achieving the Plan's goals and, to the extent feasible, how those barriers can be removed or mitigated;

(E) priorities in steps for achieving the goals of the Plan;

(F) barriers to access to appropriate mental health and substance use disorder services that meet standards of quality, access, and affordability equivalent to other components of health care, including any disparities in reimbursement rates;

(G) opportunities to integrate health care services for individuals in the custody of the Department of Corrections as part of Vermont's health care delivery system;

(H) enhancements in quality reporting and data collection to provide a more current and accurate picture of the quality of health care delivery across Vermont; and

(I) systems to ensure that reported data is shared with and is accessible to the health care professionals who are providing care, enabling them to track performance and inform improvement.

(c)(1) On or before January 15, 2027, the Agency shall provide the Plan to the House Committees on Health Care and on Human Services and the Senate Committee on Health and Welfare.

(2) The Agency shall prepare an updated Plan every two years and shall provide it to the General Assembly on or before December 1 of every other year, beginning on December 1, 2029.

Sec. 9. 18 V.S.A. § 9403a is added to read:

§ 9403a. HEALTH CARE DELIVERY ADVISORY COMMITTEE

(a) There is created the Health Care Delivery Advisory Committee to:

(1) establish health care affordability benchmarks;

(2) evaluate and monitor the performance of Vermont's health care system and its impacts on population health outcomes;

(3) collaborate with the Agency of Human Services and other interested stakeholders in the development and maintenance of the Statewide Health Care Delivery Strategic Plan developed pursuant to section 9403 of this title;

(4) advise the Green Mountain Care Board on the design and implementation of an ongoing evaluation process to continuously monitor current performance in the health care delivery system; and

(5) provide coordinated and consensus recommendations to the General Assembly on issues related to health care delivery and population health.

(b)(1) The Advisory Committee shall be composed of the following 19 members:

(A) the Secretary of Human Services or designee;

(B) the Chair of the Green Mountain Care Board or designee;

(C) the Chief Health Care Advocate from the Office of the Health Care Advocate or designee;

(D) a member of the Health Equity Advisory Commission, selected by the Commission's Chair;

(E) one representative of commercial health insurers offering major medical health insurance plans in Vermont, selected by the Commissioner of Financial Regulation;

(F) two representatives of Vermont hospitals, selected by the Vermont Association of Hospitals and Health Systems, who shall represent

hospitals that are located in different regions of the State and that face different levels of financial stability;

(G) one representative of Vermont's federally qualified health centers, selected by Bi-State Primary Care Association;

(H) one representative of physicians, selected by the Vermont Medical Society;

(I) one representative of independent physician practices, selected by HealthFirst;

(J) one representative of advanced practice registered nurses, selected by the Vermont Nurse Practitioners Association;

(K) one representative of Vermont's free clinic programs, selected by Vermont's Free & Referral Clinics;

(L) one representative of Vermont's designated and specialized service agencies, selected by Vermont Care Partners;

(M) one preferred provider from outside the designated and specialized service agency system, selected by the Commissioner of Health;

(N) one Vermont-licensed mental health professional from an independent practice, selected by the Commissioner of Mental Health;

(O) one representative of Vermont's home health agencies, selected jointly by the VNAs of Vermont and Bayada Home Health Care;

(P) one representative of long-term care facilities, selected by the Vermont Health Care Association;

(Q) one representative of small businesses, selected by the Vermont Chamber of Commerce; and

(R) the Executive Director of the Vermont Program for Quality in Health Care or designee.

(2) The Secretary of Human Services or designee shall be the Chair of the Advisory Committee.

(3) The Agency of Human Services shall provide administrative and technical assistance to the Advisory Committee.

(c) Members of the Advisory Committee shall not receive per diem compensation or reimbursement of expenses for their participation on the Advisory Committee.

Sec. 9a. 18 V.S.A. § 9407 is added to read:

§ 9407. COMPREHENSIVE PRIMARY HEALTH CARE STEERING COMMITTEE

(a) There is created the Comprehensive Primary Health Care Steering Committee to inform the work of State government, including the Blueprint for Health and the Office of Health Care Reform in the Agency of Human Services, as it relates to access to, delivery of, and payment for primary care services in Vermont.

(b) The Steering Committee shall be composed of the following members:

(1) the Chair of the Department of Family Medicine at the University of Vermont Larner College of Medicine or designee;

(2) the Chair of the Department of Pediatrics at the University of Vermont Larner College of Medicine or designee;

(3) the Associate Dean for Primary Care at the University of Vermont Larner College of Medicine or designee;

(4) the Executive Director of the Vermont Child Health Improvement Program at the University of Vermont Larner College of Medicine or designee;

(5) the President of the Vermont Academy of Family Physicians or designee;

(6) the President of the American Academy of Pediatrics, Vermont Chapter, or designee;

(7) a member of the Green Mountain Care Board's Primary Care Advisory Committee, selected by the Green Mountain Care Board;

(8) the Executive Director of the Blueprint for Health;

(9) a primary care clinician who practices at an independent practice, selected by HealthFirst;

(10) a primary care clinician who practices at a federally qualified health center, selected by Bi-State Primary Care Association;

(11) a primary care physician, selected by the Vermont Medical Society;

(12) a primary care physician assistant, selected by the Physician Assistant Academy of Vermont;

(13) a primary care nurse practitioner, selected by the Vermont Nurse Practitioners Association;

(14) a mental health provider who practices at a community mental health center designated pursuant to section 8907 of this title, selected by Vermont Care Partners;

(15) a licensed independent clinical social worker, selected by the National Association of Social Workers, Vermont Chapter; and

(16) a psychologist, selected by the Vermont Psychological Association.

(c) The Steering Committee shall:

(1) engage in an ongoing assessment of comprehensive primary care needs in Vermont;

(2) provide recommendations for recruiting and retaining high-quality primary care providers, including on ways to encourage new talent to join Vermont's primary care workforce;

(3) develop proposals for sustainable payment models for primary care;

(4) identify methods for enhancing Vermonters' access to primary care;

(5) recommend opportunities to reduce administrative burdens on primary care providers;

(6) recommend mechanisms for measuring the quality of primary care services delivered in Vermont;

(7) provide input into the Statewide Health Care Delivery Strategic Plan as it is developed, updated, and implemented pursuant to section 9403 of this title;

(8) consult with the Green Mountain Care Board in the event that the Board develops reference-based pricing for primary care providers as permitted under subdivision 9376(e)(5) of this title; and

(9) offer additional recommendations and guidance to the Blueprint for Health, the Office of Health Care Reform, the General Assembly, and others in State government on ways to increase access to primary care services and to improve patient and provider satisfaction with primary care delivery in Vermont.

(d) The Steering Committee shall receive administrative and technical assistance from the Agency of Human Services.

(e)(1) The Executive Director of the Blueprint for Health shall call the first meeting of the Steering Committee to occur on or before September 1, 2025.

(2) The Steering Committee shall select a chair from among its members at the first meeting.

(3) A majority of the membership of the Steering Committee shall constitute a quorum.

(f) Members of the Steering Committee shall not receive per diem compensation or reimbursement of expenses for their participation on the Steering Committee.

* * * Data Integration; Data Sharing * * *

Sec. 10. INTEGRATION OF HEALTH CARE DATA; REPORT

(a) The Agency of Human Services shall collaborate with the Health Information Exchange Steering Committee to evaluate the potential for developing an integrated statewide system of clinical and claims data. The Agency's analysis shall address:

(1) the feasibility of developing an integrated statewide system of clinical and claims data;

(2) the potential uses of an integrated statewide system of clinical and claims data;

(3) whether and to what extent an integrated statewide system of clinical and claims data would:

(A) improve patient, provider, and payer access to relevant information;

(B) reduce administrative burdens on providers;

(C) increase access to and quality of health care for Vermonters; and

(D) reduce costs and, if so, how to measure such reductions;

(4) appropriate privacy and security safeguards for an integrated statewide system of clinical and claims data; and

(5) any additional considerations regarding an integrated statewide system of clinical and claims data that the Agency and the Health Information Exchange Steering Committee deem appropriate.

(b) On or before January 15, 2026, the Agency of Human Services shall provide its findings and recommendations regarding development of an integrated statewide system of clinical and claims data to the House Committee on Health Care and the Senate Committee on Health and Welfare. In addition to the information required pursuant to subsection (a) of this section, the Agency shall explain the advantages and disadvantages of developing an integrated statewide system of clinical and claims data; provide the Agency's recommendations regarding whether the State should pursue development and implementation of such an integrated system; and describe the value, if any, that such an integrated system would bring to Vermont's health care system. The Agency shall not begin implementation of an integrated statewide system of clinical and claims data unless and until directed to do so by legislation enacted by the General Assembly.

Sec. 11. 18 V.S.A. § 9374 is amended to read:

§ 9374. BOARD MEMBERSHIP; AUTHORITY

* * *

(i)(1) In addition to any other penalties and in order to enforce the provisions of this chapter and empower the Board to perform its duties, the Chair of the Board may issue subpoenas, examine persons, administer oaths, and require production of papers and records. Any subpoena or notice to produce may be served by registered or certified mail or in person by an agent of the Chair. Service by registered or certified mail shall be effective three business days after mailing. Any subpoena or notice to produce shall provide at least six business days' time from service within which to comply, except that the Chair may shorten the time for compliance for good cause shown. Any subpoena or notice to produce sent by registered or certified mail, postage prepaid, shall constitute service on the person to whom it is addressed.

(2) Each witness who appears before the Chair under subpoena shall receive a fee and mileage as provided for witnesses in civil cases in Superior Courts; provided, however, any person subject to the Board's authority shall not be eligible to receive fees or mileage under this section.

(3) The Board may share any information, papers, or records it receives pursuant to a subpoena or notice to produce issued under this section with the Agency of Human Services or the Department of Financial Regulation, or

both, as appropriate to the work of the Agency or Department, provided that the Agency or Department agrees to maintain the confidentiality of any information, papers, or records that are exempt from public inspection and copying under the Public Records Act.

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* * * Health Care Reforms Addressing Exigent Needs * * *

Sec. 11a. HEALTH CARE SPENDING REDUCTIONS;
AGENCY OF HUMAN SERVICES; REPORTS

(a)(1) The Agency of Human Services shall facilitate collaboration and coordination among health care providers in order to encourage cooperation in developing rapid responses to the urgent financial pressures facing the health care system and to identify opportunities to increase efficiency, improve the quality of health care services, reduce spending on prescription drugs, and increase access to essential services, including primary care, emergency departments, mental health and substance use disorder treatment services, prenatal care, and emergency medical services and transportation, while reducing hospital spending for hospital fiscal year 2026 by not less than 2.5 percent.

(2) The Agency of Human Services shall facilitate and supervise the participation of hospitals and other health care providers in the process set forth in subdivision (1) of this subsection as necessary for this collaborative

process to be afforded state-action immunity under applicable federal and State antitrust laws.

(b) The Agency of Human Services shall report on the proposed reductions that it has approved pursuant to this section, including applicable timing and appropriate accountability measures, to the Health Reform Oversight Committee and the Joint Fiscal Committee on or before July 1, 2025. On or before the first day of each month of hospital fiscal year 2026, beginning on October 1, 2025, the Agency shall provide updates to the Health Reform Oversight Committee and the Joint Fiscal Committee when the General Assembly is not in session, and to the House Committee on Health Care and the Senate Committee on Health and Welfare when the General Assembly is in session, regarding progress in implementing and achieving the hospital spending reductions identified pursuant to this section.

Sec. 11b. HEALTH CARE SYSTEM TRANSFORMATION; AGENCY OF HUMAN SERVICES; REPORTS

(a) The Agency of Human Services shall identify specific outcome measures for determining whether, when, and to what extent each of the following goals of its health care system transformation efforts pursuant to 2022 Acts and Resolves No. 167 (Act 167) has been met:

(1) reduce inefficiencies;

(2) lower costs;

(3) improve health outcomes;

(4) reduce health inequities; and

(5) increase access to essential services.

(b)(1) On or before July 1, 2025, the Agency of Human Services shall report to the Health Reform Oversight Committee and the Joint Fiscal Committee:

(A) the specific outcome measures developed pursuant to subsection (a) of this section, along with a timeline for accomplishing them;

(B) how the Agency will determine its progress in accomplishing the outcome measures and achieving the transformation goals, including how it will determine the amount of savings attributable to each inefficiency reduced and how it will evaluate increases in access to essential services;

(C) the impact that each transformation decision made by an individual hospital as part of the Act 167 transformation process has or will have on the State's health care system, including on health care costs and on health insurance premiums;

(D) how the Agency is tracking and coordinating the transformation efforts of individual hospitals to ensure that they complement the transformation efforts of other hospitals and other health care providers and that they will contribute in a positive way to a transformed health care system that meets the Act 167 goals; and

(E) the amount of State funds, and federal funds, if applicable, that the Agency has spent on Act 167 transformation efforts to date or has obligated for those purposes and the amount of unspent State funds appropriated for Act 167-related purposes that remain for the Agency's Act 167 transformation efforts.

(2) On or before the first day of each month beginning on August 1, 2025, the Agency shall provide the Health Reform Oversight Committee and the Joint Fiscal Committee when the General Assembly is not in session, and to the House Committee on Health Care and the Senate Committee on Health and Welfare when the General Assembly is in session, with updates on each of the items set forth in subdivisions (1)(A)–(E) of this subsection.

Sec. 11c. HEALTH CARE SYSTEM TRANSFORMATION; INCENTIVES; TELEHEALTH

(a) To encourage hospitals to engage proactively, think expansively, and propose transformation initiatives that will reduce costs to Vermont's health care system without negatively affecting health care quality or jeopardizing access to necessary services, the Agency of Human Services shall award grants to the hospitals in State fiscal year 2026 that actively participate in health care transformation efforts to assist them in building partnerships, reducing hospital costs for hospital fiscal year 2026, and expanding Vermonters' access to health care services, including those delivered using telehealth. It is the intent of the

General Assembly that the funds appropriated in Sec. 18(b) of this act should be awarded on a first-come, first-served basis until all of the funds have been distributed.

(b) On or before November 15, 2025, the Agency of Human Services shall report to the Health Reform Oversight Committee and the Joint Fiscal Committee regarding how much of the $2,000,000.00 appropriated to the Agency pursuant to Sec. 18(b) of this act was obligated as of November 1, 2025 and how much had already been disbursed to hospitals as of that date.

Sec. 11d. DEPARTMENT OF FINANCIAL REGULATION; DOMESTIC HEALTH INSURER SUSTAINABILITY; REPORT

On or before November 1, 2025, the Department of Financial Regulation shall provide to the Health Reform Oversight Committee a plan for preserving the sustainability of domestic health insurers in Vermont, which may include utilizing reinsurance.

* * * Retaining Accountable Care Organization Capabilities * * *

Sec. 12. RETAINING ACCOUNTABLE CARE ORGANIZATION CAPABILITIES; REPORT

The Agency of Human Services shall explore opportunities to retain capabilities developed by or on behalf of a certified accountable care organization that were funded in whole or in part using State or federal monies,

or both, and that have the potential to make beneficial contributions to Vermont's health care system, such as capabilities related to comprehensive payment reform and quality data measurement and reporting. On or before November 1, 2025, the Agency of Human Services shall report its findings and recommendations to the Health Reform Oversight Committee.

* * * Implementation Updates * * *

Sec. 13. [Deleted.]

Sec. 14. GREEN MOUNTAIN CARE BOARD; IMPLEMENTATION; REPORT

On or before February 15, 2026, the Green Mountain Care Board shall provide an update to the House Committee on Health Care and the Senate Committee on Health and Welfare regarding the Board's implementation of this act, including the status of its efforts to establish methodologies for and begin implementation of reference-based pricing, and the effects of these efforts and activities on increasing access to care, improving the quality of care, and reducing the cost of care in Vermont. The Board shall also report on the potential future use of global hospital budgets, including providing the Board's definition of the term "global hospital budgets"; determining whether it is feasible to develop and implement global hospital budgets for Vermont hospitals and, if so, over what time period; and the advantages and disadvantages of pursuing global hospital budgets.

Sec. 15. 3 V.S.A. § 3027 is amended to read:

§ 3027. HEALTH CARE SYSTEM REFORM; IMPROVING QUALITY AND AFFORDABILITY; REPORT

(a) The Director of Health Care Reform in the Agency of Human Services shall be responsible for the coordination of health care system reform efforts among Executive Branch agencies, departments, and offices, and for coordinating with the Green Mountain Care Board established in 18 V.S.A. chapter 220.

(b) On or before February 15 annually, the Agency of Human Services shall provide an update to the House Committee on Health Care and the Senate Committee on Health and Welfare regarding all of the following:

(1) The status of the Agency's efforts to develop, update, and implement the Statewide Health Care Delivery Strategic Plan in accordance with 18 V.S.A. § 9403. The Agency shall adopt an evaluation framework using an evidence-based approach to assess both the effectiveness of Plan development and implementation and the Plan's overall impact. The evaluation shall include identifying what was accomplished, how well it was executed, and the benefits to specific cohorts within Vermont's health care system, and the Agency shall include updated evaluation results annually as part of its report.

(2) The activities of the Health Care Delivery Advisory Committee established pursuant to 18 V.S.A. § 9403a during the previous calendar year.

(3) The effects of the Statewide Health Care Delivery Strategic Plan, the efforts and activities of the Health Care Delivery Advisory Committee, and other efforts and activities engaged in or directed by the Agency on increasing access to care, improving the quality of care, and reducing the cost of care in Vermont.

Sec. 16. 18 V.S.A. § 9375(d) is amended to read:

(d) Annually on or before January 15, the Board shall submit a report of its activities for the preceding calendar year to the House Committee on Health Care and the Senate Committee on Health and Welfare.

(1) The report shall include:

* * *

(G) the status of its efforts to establish methodologies for and begin implementation of reference-based pricing and any considerations regarding the future use of global hospital budgets, and the effects of these efforts and activities on increasing access to care, improving the quality of care, and reducing the cost of care in Vermont;

(H) any recommendations for modifications to Vermont statutes; and

~~(H)~~(I) any actual or anticipated impacts on the work of the Board as a result of modifications to federal laws, regulations, or programs.

* * *

* * * Positions; Appropriations * * *

Sec. 17. GREEN MOUNTAIN CARE BOARD; POSITIONS

(a) The establishment of the following three new permanent classified positions is authorized at the Green Mountain Care Board in fiscal year 2026:

(1) one Director, Reference-Based Pricing;

(2) one Project Manager, Reference-Based Pricing; and

(3) one Operations, Procurement, and Contractual Oversight Manager.

(b) These positions shall be transferred and converted from existing vacant positions in the Executive Branch.

Sec. 18. APPROPRIATIONS

(a) The sum of $2,200,000.00 is appropriated from the General Fund to the Agency of Human Services in fiscal year 2026 for use as follows:

(1) $2,000,000.00 for feasibility analysis and transformation plan development with hospitals, designated agencies, primary care organizations, and other community-based providers;

(2) $100,000.00 for development of quality and access measures, targets, and monitoring strategies for the Statewide Health Care Delivery Strategic Plan; and

(3) $100,000.00 to support the development of alternative payment models.

(b) Notwithstanding any provision of 32 V.S.A. § 10301 to the contrary, the sum of $2,000,000.00 is appropriated from the Health IT-Fund to the

Agency of Human Services in fiscal year 2026 for grants to hospitals for the collaborative efforts to reduce hospital costs in accordance with Secs. 11a and 11c of this act and to expand access to health care services, such as by enhancing telehealth infrastructure development.

(c)(1) The sum of $1,062,500.00 is appropriated to the Green Mountain Care Board in fiscal year 2026 for use as follows:

(A) $512,500.00 for the positions authorized in Sec. 17 of this act, as set forth in subdivision (2) of this subsection (c);

(B) $500,000.00 from the General Fund for contracts, including contracts for assistance with implementing reference-based pricing in accordance with this act; and

(C) $50,000.00 from the General Fund for a contract with the Vermont Program for Quality in Health Care to engage in quality initiatives in accordance with this act.

(2) Of the funds appropriated in subdivision (1)(A) of this subsection:

(A) $205,000.00 is appropriated from the General Fund; and

(B) $307,500.00 is appropriated from the Green Mountain Care Board Regulatory and Administrative Fund.

(d) Notwithstanding any provision of 32 V.S.A. § 10301 to the contrary, the sum of $150,000.00 is appropriated from the Health IT-Fund to the Green Mountain Care Board in fiscal year 2026 for expenses associated with

increased standardization of electronic hospital budget data submissions in accordance with Sec. 4 of this act.

* * * Effective Dates * * *

Sec. 19. EFFECTIVE DATES

(a) Secs. 16 (18 V.S.A. § 9375(d); Green Mountain Care Board annual report), 17 (Green Mountain Care Board; positions), and 18 (appropriations) shall take effect on July 1, 2026.

(b) The remaining sections shall take effect on passage.