TO THE HOUSE OF REPRESENTATIVES:

The Committee on Health Care to which was referred Senate Bill No. 126 entitled "An act relating to health care payment and delivery system reform" respectfully reports that it has considered the same and recommends that the House propose to the Senate that the bill be amended 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 ~~promote the~~ **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, and regional access to services;

(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, ~~reducing~~ **controlling** commercial health insurance premiums, and managing hospital costs based on the total cost of care, beginning with reference-based pricing and continuing on to global hospital budgets; ~~and~~

(4) ~~improving population health and increasing access to health insurance coverage~~ **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 (Rep. Goldman).

* * * 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 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~~, including establishing standards for global hospital budgets that reflect the implementation of reference-based pricing and the total cost of care targets determined in collaboration with federal partners and other stakeholders or as set by the Statewide Health Care Delivery Plan developed pursuant to section 9403 of this title, once established. Beginning not later~~

~~than hospital fiscal year 2028, the Board shall establish global hospital budgets for one or more Vermont hospitals that are not critical access hospitals. By hospital fiscal year 2030, the Board shall establish global hospital budgets for all Vermont hospitals~~.

* * *

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 ~~health insurers in this State shall pay to~~ hospitals **and other health care professionals [GMCB] shall accept as payment in full** for items provided and services delivered in Vermont. ~~The purposes of reference-based pricing are to contain costs and to move health care professionals toward a site-neutral pricing structure while also allowing the Board to differentiate prices among health care professionals based on factors such as demographics, population health in a given hospital service area, payer mix, acuity, social risk factors, and a specific health care professional's role in Vermont's health care system.~~ 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 approach~~

~~reference-based pricing in an effort~~ to achieve all-payer alignment on **the** design and implementation of ~~the program~~ **reference-based pricing**.

(B) The Board shall implement reference-based pricing in a manner that does not allow [hospitals? 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 ~~for the item provided or service delivered~~ [GMCB would strike].

(2)(A) Reference-based prices established pursuant to this subsection (e) shall be based on a percentage of the Medicare reimbursement rate **[and methodologies? BCBSVT yes, GMCB no]** for the same or a similar item or service **or on another benchmark, as appropriate**, provided that ~~after~~ **if** the Board establishes initial 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 other payment or pricing systems where appropriate [GMCB; if keep this maybe delete "another benchmark" above?].**

(B) In establishing reference-based prices **for a hospital** pursuant to this subsection (e), the Board shall **[may? GMCB]** 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 ~~health insurers in this State shall pay to~~ Vermont hospitals **shall accept as payment in full** for items ~~provided~~ and services ~~delivered to individuals covered by the health insurer's plans as soon as practicable but not later than hospital fiscal year 2027~~ **covered by a plan offered or administered by a health insurer [GMCB]**. **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 shall implement reference-based pricing in a manner that does not allow hospitals to charge or collect from patients any amount in excess of the reference-based amount established by the Board for the item provided or service delivered.~~ ***[moved to subdiv. (1) above]***

(B) The Board, in collaboration with the Department of Financial Regulation, shall monitor the implementation of reference-based pricing to ensure that any ~~decreased prices~~ **decreases in amounts** paid to hospitals **also** result in ~~commensurate~~ 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 ~~Agency of Human Services, in consultation with the~~ Green Mountain Care Board, **in consultation with the Agency of Human Services and the Comprehensive Primary Health Care Steering Committee established pursuant to 18 V.S.A. § 710 [Rep. Black]**, 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 health insurers must pay 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.

Sec. 3a. 18 V.S.A. § 9451 is amended to read: **(NEW – adds definition)**

§ 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

~~(a) Hospitals shall file the following information at the time and place and in the manner established by the Board:~~ **[subsec. (a) will be removed from bill but existing language not repealed]**

~~* * *~~

~~(6) known depreciation schedules on existing buildings, a four-year capital expenditure projection, and a one-year capital expenditure plan; and~~

~~(7) the number of employees of the hospital whose duties are primarily administrative in nature, as defined by the Board, and the number of employees whose duties primarily involve delivering health care services directly to hospital patients;~~

~~(8) information regarding base salaries and total compensation for the hospital's executive and clinical leadership and for its employees who deliver health care services directly to hospital patients;~~

~~(9) proposals for ways in which the hospital can support community-based, independent, and nonhospital providers, including mental health and substance use disorder treatment providers, primary care providers, long-term care providers, and physical therapists; services provided through the Blueprint for Health, Choices for Care, and Support and Services at Home (SASH); investments in the health care workforce; and other nonhospital aspects of Vermont's health and human services systems that affect population health outcomes, including the social drivers of health; and~~

~~(10) such other information as the Board may require.~~

*** * ***

(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;

~~(7) exclude revenue derived from primary care, mental health care, and substance use disorder treatment services when determining a hospital's net patient revenue and any total cost of care targets;~~

~~(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)~~(A)~~ 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.

~~(B)(i) Beginning not later than hospital fiscal year 2028, the Board shall establish global hospital budgets for one or more Vermont hospitals that are not critical access hospitals. Not later than hospital fiscal year 2030, the Board shall establish global hospital budgets for all Vermont hospitals.~~

~~(ii) Global hospital budgets established pursuant to this section shall include Medicare to the extent permitted under federal law but shall not include Medicaid.~~

* * *

(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 (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, **the communities within the affected hospital service area,** and the members of the General Assembly who represent the hospital service area not less than 90 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 (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) As used in this section, "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.~~

(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 ~~or take appropriate~~ **any** action ~~as~~ **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.

~~(e) Any final action, order, or other determination by the Board pursuant to this section shall be subject to appeal in accordance with the provisions of section 9381 of this title.~~

* * * 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 18 V.S.A. § 710 [Rep. Black],** 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 [Rep. Donahue] p**romote 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 ~~across Vermont~~.

~~(3) Strive to make mental health services, substance use disorder treatment services, emergency medical services, nonemergency medical services, and nonmedical services and supports available in each region of Vermont.~~

(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, including benchmarks for evaluating progress. [VPQHC]

(4) Establish performance metrics and accountability measures to track systemwide progress, promote transparency, and support continuous improvement. [VPQHC]

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

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

(7) Incorporate an evaluation framework using a results-based accountability 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. [based on VPQHC; does this belong in the Plan itself or as a separate report?]

(8) 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. [Rep. Berbeco; combine with language in (4) above?]

(9) Provide annual targets for the total cost of care across Vermont's health care system ~~and include reasonable annual cost growth rates while excluding from hospital total cost of care targets all revenue derived from a hospital's investments in primary care, mental health care, and substance use disorder treatment services~~. 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.

(10) 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; ~~and~~

(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; [VMS]

(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; [VMS] and

(J) such additional sources of data and information as the ~~Board,~~ Agency~~, and Department~~ **and other stakeholders** deem appropriate.

(6) Identify:

(A) gaps in access to care**, including disparities in access resulting from geographic or demographic factors or health status [Rep. Donahue],**

as well as unnecessary duplication of services, ~~as well as~~ **including** circumstances in which service closures or consolidations ~~could~~ **may** result in improvements in quality, access, and affordability;

(B) opportunities to reduce administrative burdens, such as **simplifying certain** complexities in contracting and payment terms**, streamlining methods of data entry and clinical information sharing [VMS],** and **eliminating or combining** duplicative quality reporting requirements; ~~and~~

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

(D) opportunities to improve the quality of care across the health care delivery system; [VPQHC]

(E) priorities in steps for achieving the goals of the Plan [Rep. Donahue];

(F) barriers to adequate mental health and substance use disorder treatment services resulting from a lack of parity in reimbursement rates [Rep. Donahue];

(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, including through expanded use of telehealth; [Rep. Cina]

(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; [VPQHC]

(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 efforts; and [VPQHC]

(J) exemplars of high-quality care to stimulate best practice dissemination and strengthen Vermont's learning health system [VPQHC].

~~(c) The Green Mountain Care Board shall contribute data and expertise related to its regulatory duties and its efforts pursuant to 2022 Acts and Resolves No. 167. The Agency of Human Services shall contribute data and expertise related to its role as the State Medicaid agency, its work with community-based providers, and its efforts pursuant to 2022 Acts and Resolves No. 167.~~

~~(d)(1) From 2025 through 2027, the Agency of Human Services shall engage with stakeholders; collect and analyze data; gather information obtained through the processes established in 2022 Acts and Resolves No. 167, Secs. 1 and 2; and solicit input from the public.~~

~~(2) In 2028, the Agency shall prepare the Plan.~~

(c)**(1)** On or before January 15, ~~2029~~ **2027**, the Agency shall ~~present~~ **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 ~~three~~ **two** years and shall ~~present~~ **provide** it to the General Assembly on or before ~~January 15 every third year after 2029~~ **December 1 of every other year, beginning on December 1, 2028**.

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~~, including for affordability of commercial health insurance~~;

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

(3) collaborate with ~~the Green Mountain Care Board,~~ the Agency of Human Services~~, the Department of Financial Regulation,~~ 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 ~~14~~ **17** 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) one representative of commercial health insurers offering major medical health insurance plans in Vermont, selected by the Commissioner of Financial Regulation;

(E) 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;

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

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

(H) one representative of independent physician practices, selected ~~jointly by the Vermont Medical Society and~~ **by** HealthFirst;

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

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

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

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

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

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

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

(P) one representative of small businesses, selected by the Vermont Chamber of Commerce.

(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. § 710 is added to read: (NEW section – Rep. Black)

§ 710. 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 Medical Center or designee;

(2) the Chair of the Department of Pediatrics at the University of Vermont Medical Center 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 physician who practices at an independent practice, selected by HealthFirst;

(10) a primary care physician 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 18 V.S.A. § 8907, 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 9384(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 Blueprint for Health.

(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. 18 V.S.A. § 9353 is added to read:~~

~~§ 9353. INTEGRATION OF HEALTH CARE DATA~~

Sec. 10. INTEGRATION OF HEALTH CARE DATA; REPORT

(a) The Agency of Human Services shall collaborate with the Health Information Exchange Steering Committee ~~in the development of~~ **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 ~~in order to~~ **an integrated statewide system of clinical and claims data would:**

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

(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.

~~(b) The Agency's process shall:~~

~~(1) align with the statewide Health Information Technology Plan established pursuant to section 9351 of this title;~~

~~(2) utilize the expertise of the Health Information Exchange Steering Committee;~~

~~(3) incorporate appropriate privacy and security standards;~~

~~(4) determine how best to integrate clinical data, claims data, and data regarding social drivers of health and health-related social needs;~~

~~(5) ensure interoperability among contributing data sources and applications to enable a Unified Health Data Space that is usable by all stakeholders;~~

~~(6) identify the resources necessary to complete data linkages for clinical and research usage;~~

~~(7) establish a timeline for setup and access to the integrated system;~~

~~(8) develop and implement a system that ensures rapid access for patients, providers, and payers; and~~

~~(9) identify additional opportunities for future development, including incorporating new data types and larger populations.~~

~~(c) Health insurers, as defined in section 9402 of this title, shall provide clinical and claims data to the Agency of Human Services as directed by the Agency in order to facilitate the integrated system of clinical and claims data as set forth in this section.~~

~~(d) The Agency shall provide access to data to State agencies and health care providers as needed to support the goals of the Statewide Health Care Delivery Plan established pursuant to section 9403 of this title, once established, to the extent permitted by the data use agreements in place for each data set.~~

~~(e) On or before January 15 annually, the Agency of Human Services shall provide an update to the House Committees on Health Care and on Human Services and the Senate Committee on Health and Welfare regarding the development and implementation of the integrated system of clinical and claims data in accordance with this section.~~

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 ~~another State agency~~ **the Agency of Human Services or the Department of**

Financial Regulation, or both, as appropriate to the work of ~~that agency~~ **the Agency or Department**, provided that the ~~receiving agency~~ **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.

* * *

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

[Rep. Houghton language]

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

(a) The Agency of Human Services shall ~~organize the State into regions in which~~ **facilitate** collaboration and coordination among health care providers ~~may~~ **in order to identify opportunities to** increase efficiency**,** ~~and affordability. The Agency shall coordinate efforts by hospitals in each region to identify at least a 10 percent reduction in overall health care spending that can be achieved by the hospital or hospitals in that region for hospital fiscal year 2026. The proposed reductions shall not reduce~~ **improve the quality of health care services, 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 overall health care costs in Vermont's health care system for hospital fiscal year 2026 by not less than five percent**.

(b)(1) In order to encourage cooperation and candor in developing rapid responses to the urgent financial pressures facing the health care system, the representatives of hospitals and other health care providers may meet outside the presence of the Agency to develop proposals for spending reductions pursuant to this section; provided, however, that in order to ensure the supervision necessary for this collaborative process to be afforded state-action immunity under appliable federal and State antitrust laws, the Agency shall review each proposed spending reduction to evaluate:

(A) its feasibility;

(B) its consistency with the State's health care reform goals;

(C) its alignment with the goals of 2022 Acts and Resolves No. 167; and

(D) its ability to contribute toward meaningful cost reductions in hospital fiscal year 2026 without reducing access to essential services.

(2) The Agency shall modify to the extent practicable or reject any proposal that fails to meet the criteria set forth in subdivision (1) of this subsection. The Agency may approve any proposal that it determines meets the criteria set forth in subdivision (1) of this subsection and may

also work together with one or more hospitals to develop additional proposals that meet the criteria set forth in subdivision (1) of this subsection.

(c) The Agency of Human Services shall report **on** the proposed reductions **that it has approved** ~~for each region~~, 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 ~~regional~~ health care 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 that actively participate in health care transformation efforts **on a first-come, first-served basis until funds are exhausted** to assist them in

building partnerships**, reducing health care costs, and** ~~that will~~ expand**ing** Vermonters' access to health care services**, including those** delivered using telehealth.

(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 to expand Vermonters' access to telehealth services, including for telehealth infrastructure development.

Sec. 11d. GREEN MOUNTAIN CARE BOARD; UDPATES TO FISCAL YEAR 2026 HOSPITAL BUDGET GUIDANCE

Notwithstanding any provision of 18 V.S.A. chapter 221, subchapter 7 or Green Mountain Care Board rule to the contrary, in light of the significant financial vulnerabilities affecting vital aspects of Vermont's health care system, the Green Mountain Care Board shall consider modifying and is authorized to modify its fiscal year 2026 hospital budget guidance not later than May 31, 2025 in order to reduce one or more of the allowable systemwide growth targets.

Sec. 11e. 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; ~~GREEN MOUNTAIN CARE BOARD; BLUEPRINT FOR HEALTH;~~ 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. ~~AGENCY OF HUMAN SERVICES; IMPLEMENTATION; REPORT~~

~~On or before November 15, 2025, the Agency of Human Services shall provide an update to the Health Reform Oversight Committee regarding the~~

~~Agency's implementation of this act, including the status of its efforts to develop the Statewide Health Care Delivery Plan, advance health care data integration, and explore opportunities to retain accountable care organization capabilities, as well as on its hospital transformation activities pursuant to 2022 Acts and Resolves No. 167 and the effects of these efforts and activities on Vermonters and on Vermont's health care system.~~ **[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 development of global hospital budgets~~, and the effects of these efforts and activities on ~~Vermonters and on Vermont's health care system~~ **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 the status of its efforts to develop**, update,** and ~~maintain~~ **implement** the Statewide Health Care Delivery **Strategic** Plan in accordance with 18 V.S.A. § 9403~~, advance health care data integration as set forth in 18 V.S.A. § 9353, and coordinate hospital transformation activities pursuant to 2022 Acts and Resolves No. 167~~ **and on the activities of the Health Care Delivery Advisory Committee**, and the effects of these efforts and activities on ~~Vermonters and on Vermont's health care system~~ **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 ~~development~~ **any considerations regarding the future use** of global hospital budgets, and the effects of these efforts and activities on ~~Vermonters and on Vermont's health care system~~ **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.

* * *

* * * Effective Date**s** * * *

Sec. 17. EFFECTIVE DATE**S**

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

(b) ~~This act~~ **The remaining sections** shall take effect on passage.

(Committee vote: _____)

_____

Representative _____

FOR THE COMMITTEE