To: House Health Care Committee
From: Helen Labun, Executive Director, Vermont Health Care Association
Re: H. 583 *An Act Relating to Financial Transactions and Clinical Decision Making*

January 22, 2026

Thank you for the opportunity to comment on H. 583 *An Act Relating to Financial Transactions and Clinical Decision Making.*

The Vermont Health Care Association (VHCA) represents Vermont's nursing homes, assisted living residences, and residential care homes. Our membership includes 35 of Vermont's 36 currently licensed nursing homes.

VHCA has reviewed the language of this bill. Our overall conclusion is that this bill would significantly impede the current systems for funding nursing homes, eliminating the majority of common avenues for funding. It does not replace those systems with any viable alternatives. Similarly, it would prohibit the most common structures for supplying physician coverage, without providing an alternative. Some sections of this bill are in conflict with federal regulations that dictate how nursing homes must operate. Other sections are written in a non-parallel framing that makes it difficult to understand how they would be implemented in a nursing home context. Several sections of the bill create multiple additional layers of requirements on top of existing state and federal structures, in a manner that results in fragmentation and compliance barriers without any clear benefit. Finally, the proposed July 1, 2026, effective date offers no time for the health care system to understand and respond to this profound restructuring of the regulatory landscape.

VHCA opposes H. 583.

The following comments provide additional details on the basis for our opposition, along with alternative options for certain sections.

§ 9521. DEFINITIONS

The definitions used in this section produce an overly broad concept of who may be considered as having relevant control over a health care entity or health care services. VHCA represents many small providers who are navigating a complex regulatory, financial, clinical and daily services landscape, while maintaining buildings, dining, activities, transportation, and other

components of a residential health facility that must be available on a 24-hour basis. It is rare, if not impossible, to be able to manage this structure without contracting with multiple other entities. Clauses in the definitions section set the stage for almost all elements of operations to come under question and potentially disallowed. They create operational uncertainty around ordinary contracting, financing, and services arrangements. This level of uncertainty is unsustainable.

Two particular definitions we would like to highlight:

> **(12)(A) "Material change transaction" means any of the following, occurring during a single transaction or in a series of related transactions involving a health care entity within the State that has total assets, annual revenues, or anticipated annual revenues for new entities, of at least $1,000,000.00, including both in-state and out-of-state assets and revenues**

This definition places no time limit on the series of transactions (for example, the definition of transfer of ownership for nursing homes uses transactions over a 3-year period) and sets the extremely low monetary threshold of $1,000,000.00 in assets. Combined with other clauses in this bill, we are concerned that routine refinancing, lease changes and service updates will be swept into a class of prohibited activities.

> **(18) "Private equity fund" means a publicly traded or nonpublicly traded company that collects capital investments from individuals or entities and purchases a direct or indirect ownership share or controlling interest of a health care entity.**

In the absence of tremendous starting wealth, anyone engaged in health care transactions will need to raise capital and are therefore engaged in collecting investments. Health care providers routinely need to collect capital investments, and the definitions of control encompass a broad range of contracts not traditionally considered equity. As a result, this definition places a huge section of health care under a "private equity fund" label. VHCA recommends that any definition focus on entities whose *primary* purpose is to raise and return capital through the mechanism of taking an ownership share. We also recommend that individuals who contribute funds but are not part of the private equity group be explicitly excluded.

§ 9525. PROHIBITED TRANSACTIONS

VHCA objects to this section, the following text highlights reasons why.

> **(a) The following transactions are prohibited:**
>
> **(1) a transaction that would give a party ownership of the core business operations of an essential community provider, as defined in 45 C.F.R. § 156.235(c);**

We do not understand how to interpret this clause. It appears to require anyone who currently owns a provider defined as "essential" to never change the ownership structure. We would not be

able to merge smaller providers to reach a more sustainable scale, redesign coverage areas for better access, build shared services models, or allow owners to retire. VHCA does not support freezing current ownership structures.

> **(2) a transaction that involves financing the acquisition of a health care entity through the use of debt that will become an obligation of one or more of the health care entities that are party to the transaction;**

We are unclear what financing mechanism would be preferred over debt. In nursing homes, debt is most often long-term and asset-backed, used for investments in the facility. If a provider cannot take out a loan or sign a mortgage, that removes their primary financing options. The most stable financing for major nursing home projects is the Office of Housing and Urban Development Section 232 programs, which would no longer be an option for Vermont transactions if debt is disallowed. While Vermont nursing homes do not typically issue bonds to raise capital, that is a more common tool for other health care entities and would also be prohibited under a ban on using debt-based financing tools.

> **(3) a transaction that involves issuing dividends or other shareholder returns financed by debt that will become an obligation of one or more of the health care entities that are party to the transaction;**

We have questions about how compliance would be measured. For example, if a provider has underlying debt, such as a mortgage, in a year when they issue shareholder returns, would that be disqualifying? If the goal is to more specifically ban the practice of debt-funded dividend recapitalization, then we would want to first look at existing financial regulations on this practice and whether they offer adequate protections to maintain the solvency of the underlying operating business. Following such a review, it would be possible to identify specific gaps in current regulations and make an appropriately framed change.

> **(4) a transaction that involves entering into any contract or other service or purchasing arrangement with an affiliated legal entity, except for a contract or arrangement to provide services or products, or both, that are necessary to accomplish the legitimate health care purposes of the relevant health care entity and the contract or arrangement provides for compensation or reimbursement that is consistent with the fair market value of the services rendered or products delivered;**

It is confusing how this section should be interpreted and enforced. It appears to ban common practices of aggregating volume of services across multiple facility sites to secure better pricing, as a lower price is not fair market value. It is also unclear how a fair market value would be determined. For example, if a nursing facility experiences an unexpected staffing shortage and needs to bring in coverage for missing shifts (since we cannot send residents home or reduce operating hours to compensate), the premium that might be required for that short notice coverage appears to be disallowed. Without details on who is the arbiter of acceptable arrangements, clear definitions around fair market price, and guardrails against eliminating

desirable activities such as lowering prices or ensuring access to critical services, VHCA opposes this clause.

> **(5) a transaction that would result in one or more health care entities that does not accept, or that places limitations on, patients covered by Medicaid, original Medicare, or Medicare Advantage**.

This clause appears to go against multiple federal regulations for nursing homes. For example:

> Medicare Advantage is established as a voluntary contracting arrangement with providers, and the interplay of voluntary contracting plus the federal requirement for network adequacy is the primary mechanisms for providers and insurers to negotiate fair terms
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> In a nursing home setting, Medicare covers services that are primarily short-term rehabilitation, while Medicaid covers long-term residential care. These are two different types of services, and a facility measures their capacity for each separately. Facilities also have a right to be nursing home-only (just long-term care) and not skilled nursing.
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> Unlike some other health care entities, such as emergency departments or FQHCs, federal regulations require nursing homes to be selective in their admissions. The primary regulatory concern is to prevent nursing homes from admitting someone if they cannot guarantee an ability to meet all elements of that individual's care plan. Failure to effectively assess admissions against capacity results in regulatory findings and potentially large fines. A provider cannot both follow this federal requirement and place no limit on the individuals they admit.
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> This clause additionally prohibits entire classes of long-term care communities. For example, a continuous care retirement community (such as Wake Robin) is regulated as its own type of insurance product, covering someone from independent living through to nursing home level of care. There may be separately billable services to Medicare, but the concept of a resident being primarily covered by Medicare or Medicaid is not relevant to this arrangement.

§ 9531. CORPORATE PRACTICE OF MEDICINE PROHIBITED | § 9532. CORPORATE ENTITIES PERMITTED TO EMPLOY PHYSICIANS | § 9533. REGULATION OF CONTRACTS BETWEEN MEDICAL PRACTICES AND MANAGEMENT SERVICES ORGANIZATIONS

VHCA recommends striking this framework for corporate practice of medicine and replacing it with the model language proposed by the provider associations in the fall of 2025 and re-submitted as part of the Vermont Medical Society testimony, which builds from successful models implemented in other states. This language focuses on prohibiting corporate interference in clinical decision making and preserving clinician autonomy, it does not focus on preventing

medical groups from providing physicians to our state. We oppose legislation designed to reduce physician access.

Nursing homes are required to have a Medical Director and rounding physician coverage in their facilities. Because nursing homes in Vermont are not themselves medical groups and do not directly employ physicians, they contract with other groups for this coverage. It was once common to have a local hospital or other practice provide this coverage. However, the requirements for nursing home physicians have grown increasingly specialized over time – today's medical groups require sector-specific knowledge of regulations, quality improvement, data systems, recordkeeping, and billing practices. The medical group may maintain a telehealth service, or integrate contracts with telehealth services, to guarantee 24/7 access to clinicians. They additionally support their physicians in ongoing professional education to keep current with the nursing home sector best practices. This trend has intersected with an overall decline in available physician coverage in Vermont, particularly rural Vermont. As a result, it is now a common practice for Vermont nursing homes to contract with medical groups that specialize in nursing home services. While the physicians employed by these specialized medical groups are present in our state, the owners of the group (as defined in this bill) would not be practicing in Vermont. We read this language as, therefore, preventing Vermont nursing homes from accessing coverage by the medical groups that specialize in nursing home care.

Vermont is already struggling with high quality physician coverage. This bill's interpretation of corporate practice of medicine reduces our physician access for reasons unrelated to clinician autonomy. We therefore oppose this language and recommend returning to the previous recommendation.

§ 9533. REGULATION OF CONTRACTS BETWEEN MEDICAL PRACTICES AND MANAGEMENT SERVICES ORGANIZATIONS | § 9534. PROTECTIONS FOR EMPLOYED LICENSEES

VHCA supports the concept of Vermont regulating non-competition agreements in health care. One of the challenges we have experienced in overcoming workforce shortages is an inability to hire temporary workers as permanent staff due to the structure of non-competition clauses. However, we also understand that considerable work has taken place on this issue as part of a different work group over last year. Improperly structured prohibitions on non-competition clauses run the risk of exacerbating workforce shortages through being unevenly applied. We would request an opportunity to revisit this section in the context of the work that has already happened.

§ 9541. REPORTING OF OWNERSHIP AND CONTROL OF HEALTH CARE ENTITIES | § 9542. SHARING OF OWNERSHIP INFORMATION TO IMPROVE TRANSPARENCY

Nursing homes follow extensive reporting requirements at both state and federal levels. Examples of the types of reporting include:

- Audited financial statements to Vermont's Division of Rate Setting
- Cost reports, which are then audited, to Vermont's Division of Rate Setting
- Costs and financial reports to Medicare
- Affiliated entity identification and payments to Medicare
- Payroll records to CMS every quarter
- Ownership structure, control interests, real estate control interests to Medicare for validation, regular revalidation, and with a material change
- Entities that provide administrative services, clinical consulting, accounting, or financial services to Medicare for validation, regular revalidation, and with a material change
- Additional reporting to the Agency of Human Services when applying for a change of ownership including extensive details on financing arrangements, ownership structures, related parties, current and future service contracts, and ownership arrangements for those contracted entities

If the Green Mountain Care Board and/or Attorney General require these details for effective regulation of Vermont's health care system, then we are open to determining how to ensure timely access to the information. However, more layers of reporting with different reporting schedules, new report filing systems, and the potential for variation in the definitions / expectations in each section depending on who is reading the data, will produce a level of fragmentation that is impossible for providers to navigate. This confusion will not increase transparency.

VHCA recommends a conversation with the Green Mountain Care Board and Attorney General about what data they require to conduct their regulatory duties and whether that data is already available from other sources before creating novel reporting structures.

§ 9547. ENFORCEMENT OF CHAPTER | § 9548. TRANSACTION OVERSIGHT AND CLINICAL DECISIONMAKING FUND

We do not understand the rationale for placing enforcement of this chapter within the Consumer Protection Act. The structures for regulating financial transactions, ownership transparency, affiliated entity and contract structure reporting, and clinical care quality, already exist at both the state and federal level. Spreading oversight out more broadly simply makes that oversight shallow.

Sec. 2. EFFECTIVE DATE

This act shall take effect on July 1, 2026.

As described in these comments, this bill represents a profound change to how health care entities are financed, what contracts and activities are permitted, and how the practice of medicine is organized in Vermont. VHCA opposes this bill in its entirety. If it were to be implemented, a July 1, 2026 start date would leave no time for health care entities to restructure in an orderly manner.