February 13, 2026

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Sent via e-mail

Re: H. 583 Threatens to Upend Vermont's Health Care System

Dear Members of the House Committee on Health Care:

The undersigned represent the spectrum of health care services in Vermont, including primary care providers, independent care providers, long term care facilities, and hospitals. We are writing on behalf of health care providers throughout Vermont to express alarm regarding H.583, a bill pertaining to health care financial transactions and clinical decision making. In short, the proposed language in H. 583 is unworkable for the health care providers and facilities of Vermont. **The bill does not just overshoot its policy goal; it fundamentally misunderstands how many health care facilities in Vermont are structured and function.** We risk serious consequences to Vermont's health care system in pursuit of a first-in-the-nation bill.

While the bill is complex and different provisions impact different provider/facility types to different extents, we all write with the clear message that **instead of preventing harmful private equity financial transactions, H.583 draft 1.2 contains blanket prohibitions, fines that exceed operating margins, and a private right of action that each individually threaten the ongoing viability of Vermont's entire health care system.** Our organizations were not consulted in the process of developing the bill nor in drafting any bill language on this topic.

Below we outline just some of the foreseeable impacts on Vermont health care providers of various sections of the bill – with many additional downstream impacts likely due to the complexity of the financial transactions implicated by the bill. **This bill cannot pass - it will devastate Vermont's health care system.** If work continues on any of the topics covered in H. 583, we recommend starting with the corporate control of medical decision-making language that several of our organizations submitted to the House Health Care Committee on January 27th and can be found here.

§ 9525 – Prohibited Health Care Facility Ownership Structures

Summary: As of January 1, 2027 (with a window for existing facilities until January 1, 2029) this section prohibits: an organization funded by capital investments from owning a health care facility; any for-profit entity from owning a health care entity, unless it is an incorporation of professional persons, professional corporation, or limited liability corporation of professional services; sale-leaseback structures.

Impact

- This language would both **decimate many Vermont health care facilities and stifle health care innovation**
- This section forces many privately owned corporations – often Vermont's smaller health care entities - including independent physician offices, ambulatory surgical centers, imaging centers, out of state physician groups offering telehealth services or remote patient monitoring, EMS and long-term care facilities to completely unwind their corporate structure. As an example, slightly more than 75% of Vermont nursing homes would need to change their ownership structure by 2029.
- A corporate restructuring would be prohibitively expensive and difficult to achieve on the timeline, as long-term leases, debt agreements, leadership contracts, management structures and other elements of financing and operations need to be dismantled and rebuilt, and then approvals sought from CMS and state licensing, and then re-enrollment completed in Medicaid and Medicare.
- Many owners would want to sell as the simplest solution, but it is unclear to whom they could sell and if there is any path for many health care organizations to restructure as allowed under the bill.
- The bill's definitions of ownership and the prohibited "private equity company" structure are so broad that they encompass common forms of financing and bar standard investment structures, even for owners who otherwise match the short list of permitted organizational structures.
- While other states have various statutory limits on ownership of medical practices, such laws were largely adopted in the early to mid-20th century, and corporate structures have been designed over time to adapt to their longstanding state laws. In Vermont, we are not beginning from a clean slate, and corporate structures cannot change without massive disruption.

§ 9531 - Corporate Practice of Medicine Prohibited

Summary: Other than exceptions listed below, this states that only Vermont-licensed MDs, DOs, PAs and APRNs may own a medical practice, employ other licensees, or otherwise engage in the practice of medicine; entities allowed to employ licensees cannot indirectly or directly interfere with, control, or otherwise direct the professional judgment or clinical decisions of a licensee.

Impact:

- Prohibits ongoing use of any physician, PA or APRN service owned by out of state licensees. **Threatens to end the use of any telehealth or remote monitoring provider** not owned by Vermont licensees; prohibits contracting with cost-effective, high quality

private **medical groups for services** such as staffing radiology services, emergency departments and providing medical director services to nursing homes.
- See also the concerns above regarding the fundamental disruptions caused by requiring changes in corporate structure.
- We support the intent of language regarding limits on interfering with or controlling professional judgment – but this list is underinclusive and in-patient care focused. This should be replaced with the language suggested by many of our organizations, referenced above and linked again here.

§ 9532 – Corporate Entities Permitted to Employ MDs, PAs and APRNs

Summary: Enumerates some entities that can employ MDs, PAs and APRNs but fails to list many other locations that may require employed medical staff or directors; limits entities that may employ licensees who are not engaged in the practice of medicine.

Impact:
- Many **additional types of settings in Vermont employ medical directors that would now be prohibited from doing so** – mental health and substance use disorder facilities/program, EMS, fire departments, ski patrol, just to name a few. It is nearly impossible to foresee all of the entities in Vermont impacted by this language and create an accurate and inclusive list.
- **Medical practitioners are precluded from *nonclinical* employment** outside of two settings – for no clear reason and creating bars on individuals' decisions to take on nonclinical employment.

§ 9533 – Regulation of Arrangements between Medical Practices and Management Services Organizations

Impact:
- This section **risks unnecessary restrictions on administrative services** offered by entities such as New England Collaborative Health Network, which help practices achieve administrative efficiency, while at the same time limits guardrails to only "medical practices" rather than other health care entities that may partner with MSOs but don't appear covered by current definitions such as substance use disorder services, optometry/eye care practices, or dental practices.
- Robust safeguards that extend to all health care entities would be created in our proposed language addressing corporate control over decision making.

§ 9534 – Prohibition on Restrictive Covenants

Impact:
- While we agree with the intent to limit restrictive covenants in health care, H. 583 **fails to address important topics** such as nonsolicitation/communication with patients; fails to address contracts issued by out of state entities, which impacts the ability to hire nurses leaving staffing agencies; and fails to address pay or stay provisions. All of these, as well

as a stronger health care specific bar on noncompetes, are well addressed in the latest draft of H. 205, currently moving through the House Commerce Committee.

Subchapter 4 - Reporting Requirements – Audit Authority - Fines

Summary: These sections require extensive reporting very two years by every "health care entity" in the state - including individual practices, groups of more than two individual licensees, and facilities- including reporting of every individual with an ownership or investment interest in the health care entity, organizational charts and audited financial statements. All of this information is deemed public and not confidential. The Attorney General and the Green Mountain Care Board are authorized to independently or jointly audit and inspect the records of any health care entity that fails to submit complete information. Fines for missing or false reports are $50,000 or $500,000, depending on the size of entity.

Impact:

- Multi-layered, detailed reporting requirements **pose significant administrative burden and cost** on health care entities. **It is unclear the purpose served** by all entities providing this information, regardless of having any interaction with private equity.
- Some of these requirements conflict with, and others are duplicative with, the extensive existing federal and state reporting obligations for many health care entities, including:
    - Hospital corporate structure/corporate reporting requirements
    - FQHC reporting requirements
    - Long term care facility reporting requirements
- Not all small provider organizations may have audited financial statements available. At the same time, providing financial statements and deeming them public information, accessible to public records requests, makes organizations vulnerable to fraud, puts them at risk of negotiation disadvantage with vendors and payers, and may lead to antitrust violations.
- Subjecting small entities to audits and fines ranging from $50-500,000 for missing a reporting deadline or having incorrect information is unacceptable. These reports could be extremely complicated and it is likely that some will trigger the penalty without intentional disregard for the law. **The scale of fines proposed would put health care providers and facilities out of business**.

§ 9546 - Private Right of Action

Impact:

- The definitions and restricted practices in this bill are complicated, broad, and often define common activities as if they were a minor component of the health care landscape. Even if we had clearer definitions and guidance from involved regulators, the fact that so many activities are now in a legal gray area and there is a private right of action means that **daily work opens health care organizations up to the threat of lawsuits**. That is not an acceptable operating environment.

In summary, the proposed language in H. 583 is unworkable for the health care providers and facilities of Vermont. Providers convened over the fall to draft language to regulate and limit corporate control over health care decisions – after the expectation was set last session that stakeholders would have an opportunity to provide input on language prior to the session beginning. **Legislative language that would put meaningful guardrails in place on private equity behavior but also allow necessary investment in Vermont's health care entities can be found here.**

Sincerely,

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