

1 TO THE HOUSE OF REPRESENTATIVES:

2 The Committee on Health Care to which was referred Senate Bill No. 126  
3 entitled “An act relating to health care payment and delivery system reform”  
4 respectfully reports that it has considered the same and recommends that the  
5 House propose to the Senate that the bill be amended by striking out all after  
6 the enacting clause and inserting in lieu thereof the following:

7 \* \* \* Purpose of the Act; Goals \* \* \*

8 Sec. 1. PURPOSE; GOALS

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

12 (1) improvements in health outcomes, population health, quality of care,  
13 and regional access to services;

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

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

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

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

4                           \* \* \* Hospital Budgets and Payment Reform \* \* \*

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

6           § 9375. DUTIES

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

9           (b) The Board shall have the following duties:

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

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

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

3 \* \* \*

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

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

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

15 \* \* \*

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

17 § 9376. PAYMENT AMOUNTS; METHODS

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

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

5 (b) Rate-setting.

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

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

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

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

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

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

19 (e) Reference-based pricing.

20 (1)(A) The Board shall establish reference-based prices that represent  
21 the maximum amounts that hospitals shall accept as payment in full for

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

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

14 (2)(A) Reference-based prices established pursuant to this subsection (e)  
15 shall be based on a percentage of the Medicare reimbursement rate for the  
16 same or a similar item or service or on another benchmark, as appropriate,  
17 provided that if the Board establishes initial prices that are referenced to  
18 Medicare, the Board may opt to update the prices in the future based on a  
19 reasonable rate of growth that is separate from Medicare rates, such as the  
20 Medicare Economic Index measure of inflation, in order to provide  
21 predictability and consistency for health care professionals and payers and to

1 protect against federal funding pressures that may impact Medicare rates in an  
2 unpredictable manner. The Board may also reference **to, and update based**  
3 **on,** other payment or pricing systems where appropriate.

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

10 (3)(A) The Board shall begin implementing reference-based pricing as  
11 soon as practicable but not later than hospital fiscal year 2027 by establishing  
12 the maximum amounts that Vermont hospitals shall accept as payment in full  
13 for items **provided** and services **delivered, provided that this authority shall**  
14 **not apply to items provided or services delivered to patients who are**  
15 **enrolled in Medicaid or Medicare.** After initial implementation, the Board  
16 shall review the reference-based prices for each hospital annually as part of the  
17 hospital budget review process set forth in chapter 221, subchapter 7 of this  
18 title.

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

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

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

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

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

21 § 9451. DEFINITIONS

1 As used in this subchapter:

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

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

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

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

15 § 9454. HOSPITALS; DUTIES

16 \* \* \*

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

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

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

2 § 9456. BUDGET REVIEW

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

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

7 (1) review utilization information;

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

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

16 ~~(3)~~(4) consider the expenditure analysis for the previous year and the  
17 proposed expenditure analysis for the year under review;

18 ~~(4)~~(5) consider any reports from professional review organizations;

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

1           ~~(5)~~(7) solicit public comment on all aspects of hospital costs and use and  
2           on the budgets proposed by individual hospitals;

3           ~~(6)~~(8) meet with hospitals to review and discuss hospital budgets for the  
4           forthcoming fiscal year;

5           ~~(7)~~(9) give public notice of the meetings with hospitals, and invite the  
6           public to attend and to comment on the proposed budgets;

7           ~~(8)~~(10) consider the extent to which costs incurred by the hospital in  
8           connection with services provided to Medicaid beneficiaries are being charged  
9           to non-Medicaid health benefit plans and other non-Medicaid payers;

10          ~~(9)~~(11) require each hospital to file an analysis that reflects a reduction  
11          in net revenue needs from non-Medicaid payers equal to any anticipated  
12          increase in Medicaid, Medicare, or another public health care program  
13          reimbursements, and to any reduction in bad debt or charity care due to an  
14          increase in the number of insured individuals;

15          ~~(10)~~(12) require each hospital to provide information on administrative  
16          costs, as defined by the Board, including specific information on the amounts  
17          spent on marketing and advertising costs;

18          ~~(11)~~(13) require each hospital to create or maintain connectivity to the  
19          State’s Health Information Exchange Network in accordance with the criteria  
20          established by the Vermont Information Technology Leaders, Inc., pursuant to  
21          subsection 9352(i) of this title, provided that the Board shall not require a

1 hospital to create a level of connectivity that the State’s Exchange is unable to  
2 support;

3 ~~(12)~~(14) review the hospital’s investments in workforce development  
4 initiatives, including nursing workforce pipeline collaborations with nursing  
5 schools and compensation and other support for nurse preceptors; ~~and~~

6 ~~(13)~~(15) consider the salaries for the hospital’s executive and clinical  
7 leadership, including variable payments and incentive plans, and the hospital’s  
8 salary spread, including a comparison of median salaries to the medians of  
9 northern New England states and a comparison of the base salaries and total  
10 compensation for the hospital’s executive and clinical leadership with those of  
11 the hospital’s lowest-paid employees who deliver health care services directly  
12 to hospital patients; and

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

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

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

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

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

5           ~~(3)~~(4) promote efficient and economic operation of the hospital and, if a  
6 hospital is affiliated with a hospital network, ensure that hospital spending on  
7 the hospital network’s operations is consistent with the principles for health  
8 care reform expressed in section 9371 of this title and with the Statewide  
9 Health Care Delivery Strategic Plan, once established;

10           ~~(4)~~(5) reflect budget performances for prior years;

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

14           ~~(6)~~(7) demonstrate that they support equal access to appropriate mental  
15 health care that meets standards of quality, access, and affordability equivalent  
16 to other components of health care as part of an integrated, holistic system of  
17 care; and

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

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

4 \* \* \*

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

9 (2)(A) Except as provided in subdivision (D) of this subdivision (2), a  
10 hospital that proposes to reduce or eliminate any service in order to comply  
11 with a budget established under this section shall provide a notice of intent to  
12 the Board, the Agency of Human Services, the Office of the Health Care  
13 Advocate, and the members of the General Assembly who represent the  
14 hospital service area not less than 90 45 days prior to the proposed reduction or  
15 elimination.

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







1        (b) The Plan shall:

2            (1) Align with the principles for health care reform expressed in section  
3            9371 of this title.

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

10           (3) Define a shared vision and shared goals and objectives for improving  
11           access to and the quality, efficiency, and affordability of health care services in  
12           Vermont, including benchmarks for evaluating progress.

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

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

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

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

9           (8) Build on data and information from:

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

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

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

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

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

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

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

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

8           (I) the 2024 report on Blueprint for Health payments to patient-  
9           centered medical homes, submitted to the General Assembly by the Agency of  
10           Human Services in accordance with 2023 Acts and Resolves No. 51, Sec. 5;  
11           and

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

14           (9) Identify:

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

18           (B) gaps in access to care, including disparities in access resulting  
19           from geographic or demographic factors or health status, as well as  
20           unnecessary duplication of services, including circumstances in which service

1 closures or consolidations may result in improvements in quality, access, and  
2 affordability;

3 (C) opportunities to reduce administrative burdens;

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

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

7 (F) barriers to adequate mental health and substance use disorder  
8 treatment services;

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

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

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

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

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

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

5           § 9403a. HEALTH CARE DELIVERY ADVISORY COMMITTEE

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

7                   (1) establish health care affordability benchmarks;

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

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

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

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

18           (b)(1) The Advisory Committee shall be composed of the following 17 18  
19           members:

20                   (A) the Secretary of Human Services or designee;

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

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

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

6           (E) two representatives of Vermont hospitals, selected by the  
7           Vermont Association of Hospitals and Health Systems, who shall represent  
8           hospitals that are located in different regions of the State and that face different  
9           levels of financial stability;

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

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

14           (H) one representative of independent physician practices, selected  
15           by HealthFirst;

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

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

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

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

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

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

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

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

11          **(Q) The Executive Director of the Vermont Program for Quality**  
12          **in Health Care or designee.**

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

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

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

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

21          § 9407. COMPREHENSIVE PRIMARY HEALTH CARE STEERING

1           COMMITTEE

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

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

8           (1) the Chair of the Department of Family Medicine at the University of  
9           Vermont ~~Medical Center~~ **Larner College of Medicine** or designee;

10           (2) the Chair of the Department of Pediatrics at the University of  
11           Vermont ~~Medical Center~~ **Larner College of Medicine** or designee;

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

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

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

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

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

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

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

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

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

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

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

11           (14) a mental health provider who practices at a community mental  
12 health center designated pursuant to 18 V.S.A. § 8907, selected by Vermont  
13 Care Partners;

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

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

17           (c) The Steering Committee shall:

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

- 1           (2) provide recommendations for recruiting and retaining high-quality  
2           primary care providers, including on ways to encourage new talent to join  
3           Vermont’s primary care workforce;
- 4           (3) develop proposals for sustainable payment models for primary care;  
5           (4) identify methods for enhancing Vermonters’ access to primary care;  
6           (5) recommend opportunities to reduce administrative burdens on  
7           primary care providers;
- 8           (6) recommend mechanisms for measuring the quality of primary care  
9           services delivered in Vermont;
- 10           (7) provide input into the Statewide Health Care Delivery Strategic Plan  
11           as it is developed, updated, and implemented pursuant to section 9403 of this  
12           title;
- 13           (8) consult with the Green Mountain Care Board in the event that the  
14           Board develops reference-based pricing for primary care providers as  
15           permitted under subdivision 9376(e)(5) of this title; and
- 16           (9) offer additional recommendations and guidance to the Blueprint for  
17           Health, the Office of Health Care Reform, the General Assembly, and others in  
18           State government on ways to increase access to primary care services and to  
19           improve patient and provider satisfaction with primary care delivery in  
20           Vermont.



1           (3) whether and to what extent ~~in order to~~ an integrated statewide  
2 system of clinical and claims data would:

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

5           (B) reduce administrative burdens on providers;

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

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

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

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

13           (b) On or before January 15, 2026, the Agency of Human Services shall  
14 provide its findings and recommendations regarding development of an  
15 integrated statewide system of clinical and claims data to the House Committee  
16 on Health Care and the Senate Committee on Health and Welfare. In addition  
17 to the information required pursuant to subsection (a) of this section, the  
18 Agency shall explain the advantages and disadvantages of developing an  
19 integrated statewide system of clinical and claims data, provide the Agency's  
20 recommendations regarding whether the State should pursue development and  
21 implementation of such an integrated system, and describe the value, if any,

1 that such an integrated system would bring to Vermont’s health care system.

2 **The Agency shall not begin implementation of an integrated statewide**  
3 **system of clinical and claims data unless and until directed to do so by**  
4 **legislation enacted by the General Assembly.**

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

6 § 9374. BOARD MEMBERSHIP; AUTHORITY

7 \* \* \*

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

19 (2) Each witness who appears before the Chair under subpoena shall  
20 receive a fee and mileage as provided for witnesses in civil cases in Superior

1 Courts; provided, however, any person subject to the Board’s authority shall  
2 not be eligible to receive fees or mileage under this section.

3 (3) The Board may share any information, papers, or records it receives  
4 pursuant to a subpoena or notice to produce issued under this section with the  
5 Agency of Human Services or the Department of Financial Regulation, or  
6 both, as appropriate to the work of the Agency or Department, provided that  
7 the Agency or Department agrees to maintain the confidentiality of any  
8 information, papers, or records that are exempt from public inspection and  
9 copying under the Public Records Act.

10 \* \* \*

11 \* \* \* Health Care Reforms Addressing Exigent Needs \* \* \*

12 Sec. 11a. HEALTH CARE SPENDING REDUCTIONS;

13 AGENCY OF HUMAN SERVICES; REPORTS

14 (a) The Agency of Human Services shall facilitate collaboration and  
15 coordination among health care providers in order to identify opportunities to  
16 increase efficiency, improve the quality of health care services, **reduce**  
17 **spending on prescription drugs,** and increase access to essential services,  
18 including primary care, emergency departments, mental health and substance  
19 use disorder treatment services, prenatal care, and emergency medical services  
20 and transportation, while reducing **overall health care costs in Vermont’s**

1 health care system hospital spending for hospital fiscal year 2026 by not less  
2 than five percent.

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

11 (A) its feasibility;

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

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

14 and

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

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

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

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

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

16 (a) The Agency of Human Services shall identify specific outcome  
17 measures for determining whether, when, and to what extent each of the  
18 following goals of its health care system transformation efforts pursuant to  
19 2022 Acts and Resolves No. 167 (Act 167) has been met:

20 (1) reduce inefficiencies;

21 (2) lower costs;

- 1           (3) improve health outcomes;
- 2           (4) reduce health inequities; and
- 3           (5) increase access to essential services.

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

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

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

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

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

1           (E) the amount of State funds, and federal funds, if applicable, that  
2           the Agency has spent on Act 167 transformation efforts to date or has obligated  
3           for those purposes, and the amount of unspent State funds appropriated for Act  
4           167-related purposes that remain for the Agency’s Act 167 transformation  
5           efforts.

6           (2) On or before the first day of each month beginning on August 1,  
7           2025, the Agency shall provide the Health Reform Oversight Committee and  
8           the Joint Fiscal Committee when the General Assembly is not in session, and  
9           to the House Committee on Health Care and the Senate Committee on Health  
10           and Welfare when the General Assembly is in session, with updates on each of  
11           the items set forth in subdivisions (1)(A)–(E) of this subsection .

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

13                           TELEHEALTH

14           (a) To encourage hospitals to engage proactively, think expansively, and  
15           propose transformation initiatives that will reduce costs to Vermont’s health  
16           care system without negatively affecting health care quality or jeopardizing  
17           access to necessary services, the Agency of Human Services shall award grants  
18           to the hospitals **in State fiscal year 2026** that actively participate in health care  
19           transformation efforts on a first-come, first-served basis until funds are  
20           exhausted to assist them in building partnerships, reducing **health care hospital**

1 costs **for hospital fiscal year 2026**, and expanding Vermonters’ access to  
2 health care services, including those delivered using telehealth.

3 (b) Notwithstanding any provision of 32 V.S.A. § 10301 to the contrary,  
4 the sum of \$2,000,000.00 is appropriated from the Health IT-Fund to the  
5 Agency of Human Services in fiscal year 2026 for grants to hospitals **to expand**  
6 **Vermonters’ access to telehealth services, including for the collaborative**  
7 **efforts to reduce hospital costs in accordance with subsection (a) of this**  
8 **section and Sec. 11a of this act and to expand access to health care**  
9 **services, such as by enhancing** telehealth infrastructure development.

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

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

17 **MAY 6 MARKUP STOPPED HERE**

18 \* \* \* Retaining Accountable Care Organization Capabilities \* \* \*

19 Sec. 12. RETAINING ACCOUNTABLE CARE ORGANIZATION  
20 CAPABILITIES; **GREEN MOUNTAIN CARE BOARD;**  
21 **BLUEPRINT FOR HEALTH;** REPORT



1        On or before February 15, 2026, the Green Mountain Care Board shall  
2        provide an update to the House Committee on Health Care and the Senate  
3        Committee on Health and Welfare regarding the Board’s implementation of  
4        this act, including the status of its efforts to establish methodologies for and  
5        begin implementation of reference-based pricing and development of global  
6        hospital budgets, and the effects of these efforts and activities on Vermonters  
7        and on Vermont’s health care system increasing access to care, improving  
8        the quality of care, and reducing the cost of care in Vermont. The Board  
9        shall also report on the potential future use of global hospital budgets,  
10       including providing the Board’s definition of the term “global hospital  
11       budgets”; determining whether it is feasible to develop and implement  
12       global hospital budgets for Vermont hospitals and, if so, over what time  
13       period; and the advantages and disadvantages of pursuing global hospital  
14       budgets.

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

16       § 3027. HEALTH CARE SYSTEM REFORM; IMPROVING QUALITY  
17              AND AFFORDABILITY; REPORT

18              (a) The Director of Health Care Reform in the Agency of Human Services  
19       shall be responsible for the coordination of health care system reform efforts  
20       among Executive Branch agencies, departments, and offices, and for

1 coordinating with the Green Mountain Care Board established in 18 V.S.A.  
2 chapter 220.

3 (b) On or before February 15 annually, the Agency of Human Services  
4 shall provide an update to the House Committee on Health Care and the Senate  
5 Committee on Health and Welfare regarding the status of its efforts to develop,  
6 update, and maintain implement the Statewide Health Care Delivery  
7 Strategic Plan in accordance with 18 V.S.A. § 9403, advance health care data  
8 integration as set forth in 18 V.S.A. § 9353, and coordinate hospital  
9 transformation activities pursuant to 2022 Acts and Resolves No. 167 and on  
10 the activities of the Health Care Delivery Advisory Committee, and the  
11 effects of these efforts and activities on Vermonters and on Vermont's health  
12 care system increasing access to care, improving the quality of care, and  
13 reducing the cost of care in Vermont.

14 **Add from Sec. 8:**

15 **(7) Incorporate an evaluation framework using a results-based**  
16 **accountability approach to assess both the effectiveness of Plan**  
17 **development and implementation and the Plan's overall impact. The**  
18 **evaluation shall include identifying what was accomplished, how well it**  
19 **was executed, and the benefits to specific cohorts within Vermont's health**  
20 **care system. [based on VPOHC]**

21

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

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

5 (1) The report shall include:

6 \* \* \*

7 (G) the status of its efforts to establish methodologies for and begin  
8 implementation of reference-based pricing and development any  
9 considerations regarding the future use of global hospital budgets, and the  
10 effects of these efforts and activities on Vermonters and on Vermont's health  
11 care system increasing access to care, improving the quality of care, and  
12 reducing the cost of care in Vermont;

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

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

16 \* \* \*

17 \* \* \* Effective Dates \* \* \*

18 Sec. 17. EFFECTIVE DATES

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

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

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12

(Committee vote: \_\_\_\_\_)

\_\_\_\_\_

Representative \_\_\_\_\_

FOR THE COMMITTEE