MEMORANDUM

TO: House Committee on Health Care
FROM: Green Mountain Care Board
RE: GMCB Recommendations for Modification to S.126
DATE: April 30, 2025

The Green Mountain Care Board (GMCB) supports S.126 as an important mechanism to transform and improve Vermont's fragile health care system.

In support of these goals, the GMCB recommends the following modifications to S.126 as passed by the Senate. The first portion of this document includes a description of each matter, the location of that matter in S.126, and the GMCB's summary recommendation. Appendix A to this document is S.126 as passed by the Senate, with GMCB's recommended line-item modifications. Appendix B is the Joint Fiscal Office's fiscal note to this bill, updated April 24, 2025.

MATTER	SECTIONS	RECOMMENDATION
2027 deadline for reference-based pricing	2, 3	Recommend removing 2027 deadline but keeping language that GMCB implement reference-based pricing "as soon as practicable." GMCB supports reference-based pricing and will work expeditiously on the project. However, establishing a deadline at this stage seems premature given the State has not implemented reference-based pricing before, it's unclear exactly how long the work will take, and it's uncertain whether it will align with existing guidance and budgeting timelines.
Description of reference-based pricing	3	Recommend using reference-based prices to cap payments that hospitals can receive for services, instead of setting the amount that health insurers in Vermont must pay. This manner of reference-based pricing is least likely to generate an ERISA preemption challenge. This position is consistent with BCBS's written testimony of April 9, 2025 (page 1) and with HCA's written testimony of March 12, 2025 (page 1).
Requirement to consider a community's composition when setting	3	Recommend giving GMCB discretion to consider the composition of a community when establishing reference-based prices, rather than making this a requirement. This will allow GMCB to prioritize the site-neutral objective of reference-based pricing.

reference-based prices		This position appears consistent with BCBS's written testimony April 9, 2025 (pages 1-2).
Discretion to reference other payment or pricing systems	3	Recommend clarifying and simplifying language to state that GMCB may also reference other payment or pricing systems where appropriate. This position is consistent with BCBS's recommendation for more permissive language (page 2). BCBS also recommends basing prices on a percentage of the "Medicare reimbursement rate **and methodologies** for the same or a similar item or service." GMCB does not support this recommendation because Medicare methodologies differ across types of hospitals. This language could create unanticipated confusion and could unnecessarily complicate the pricing methodology.
Prohibition on balance billing	3	Recommend including in this prohibition non-hospital health care professionals.
Reference-based price monitoring by GMCB	3	Recommend striking language that requires GMCB and DFR to "ensure" that decreased prices result in commensurate decreases in premiums, for the reasons described in BCBS's written testimony. Recommend keeping language that requires GMCB to monitor the impact of reference-based pricing and post its findings on its website. This position is consistent with BCBS's written testimony (page 2).
Implementation of reference-based pricing by AHS for non-hospital providers	3	**Critical Change.** GMCB recommends removing this section. Under 18 V.S.A. § 9376, GMCB currently has authority to set commercial prices for hospital and non-hospital providers. It is critical that this authority not be constrained by inconsistent statutory language. This position is consistent with BCBS's written testimony (page 2) and appears consistent with AHS's written testimony of April 1, 2025 (page 1).
Requirement that GMCB exclude revenue derived from primary care when considering hospital budgets	5	**Critical Change.** If GMCB is required to exclude revenue that hospitals obtain from primary care, mental health care, and substance use disorder treatment services, hospitals will be incentivized to consider purchasing more of these services. Hospitals are generally not as cost effective at providing these services. Moreover, non-hospital primary care is generally more cost effective and more likely to consider sending referrals to cost effective treatment options. Hospital-based primary care is more likely to refer

		cases to the hospital they're associated with, which may or may not promote affordability, access, and quality of care. As BCBS explains in its written testimony, excluding hospital revenue in this manner will be more expensive for Vermonters. This language does not align with S.126's goals of reducing premiums and stabilizing non-hospital providers. This position is consistent with BCBS's written testimony (pages 2-3) and the HCA's written testimony of March 12, 2025 (page 2). See also: GMCB comment on Section 8 below.
Consideration of hospital network finances as they relate to hospital budgets	5	Recommend requiring GMCB to ensure that, if a hospital exists within a network, that hospital spending on network operations is consistent with the state's health care goals. See also: GMCB comment on Section 6 below.
Hospital notice of any proposed reduction or elimination of its services	5	Recommend that a hospital be required to provide notice to affected patients, not just to government stakeholders. In addition, recommend that a hospital be required to notify affected patients about its proposed plan for transition of care, with information about the patient's rights and options concerning storage and transfer of medical records.
GMCB's authority to take action to correct hospital network operations	6	Recommend removing the proposed GMCB authority to "take appropriate action" to correct any aspect of a hospital network's structure or financial operations. Modifying in this manner would retain GMCB's proposed authority to review and evaluate the structure of a hospital network, and to publicly recommend necessary action to align the network's operations with Vermont's health care goals. If the proposed modification to Section 5, above, is made as well, GMCB will have explicit authority to ensure that a hospital's spending on network operations is consistent with the state's health care goals.
Total cost of care targets	8	Recommend removing requirement that the Statewide Health Care Delivery Plan include annual hospital total cost of care targets that exclude all revenue derived from a hospital's investment in primary care, mental health care, and substance use disorder treatment services. This position is consistent with GMCB's position above concerning the exclusion of revenue derived from these

		services when considering hospital budgets. If modified, this section still requires the plan to establish "annual targets for the total cost of care across Vermont's health care system." GMCB believes the Health Care Delivery Advisory Committee can choose to establish a hospital-specific target with this language. However, the target would not require exclusion of revenue for these services. This position appears consistent with the HCA's written testimony of March 12, 2025 (page 2).
Integration of Health Care Data	10	Recommendations in this section are consistent with the consensus language submitted by AHS, GMCB, and the HCA on April 24, 2025. Some minor grammatical edits have been included.
GMCB authority to share information with State agencies	11	Recommend modifying to authorize GMCB to share information with "another State agency **or State officer**." This will clarify that this authorization extends to the Vermont State Auditor.

APPENDIX A

GREEN MOUNTAIN CARE BOARD PROPOSED MODIFICATIONS TO S.126

S.126

An act relating to health care payment and delivery system reform

It is hereby enacted by the General Assembly of the State of Vermont:

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

Sec. 1. PURPOSE; GOALS

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

(1) improvements in health outcomes, 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 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.

* * * 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) The Board shall establish reference-based prices that represent the ~~amounts that health insurers in this State shall pay to hospitals 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.~~maximum amounts that hospitals and other health care professionals shall accept as payment in full for items provided and services delivered in Vermont. 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 on ways to approach reference-based pricing in an effort to achieve all-payer alignment on design and implementation of the program.

(2)(A) Reference-based prices established pursuant to this subsection (e) shall be based on a percentage of the Medicare reimbursement rate for the same or a similar item or service, ~~provided that after 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.~~ where available and appropriate. The Board may also reference other payment or pricing systems where appropriate.

(B) In establishing reference-based prices pursuant to this subsection (e), the Board ~~shall~~may 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.

(3)(A) The Board shall begin implementing reference-based pricing as soon as practicable 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~~a plan offered or administered by a health insurer.

(B) The Board shall implement reference-based pricing in a manner that does not allow hospitals or other health care professionals 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~~.

(C) The Board, in collaboration with the Department of Financial Regulation, shall monitor the implementation of reference-based pricing ~~to ensure that any decreased prices paid to hospitals result in commensurate decreases in health insurance premiums. The Board~~and 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 the use of reference-based pricing in one or more hospitals, such as a reduction in access to or quality of care.

~~(5) The Agency of Human Services, in consultation with the Green Mountain Care Board, 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 Plan established pursuant to section 9403 of this title, once established.~~

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:

* * *

(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 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~~consider 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)~~(8) solicit public comment on all aspects of hospital costs and use and on the budgets proposed by individual hospitals;

~~(6)~~(9) meet with hospitals to review and discuss hospital budgets for the forthcoming fiscal year;

~~(7)~~(10) give public notice of the meetings with hospitals~~,~~ and invite the public to attend and to comment on the proposed budgets;

~~(8)~~(11) 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)~~(12) 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)~~(13) 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)~~(14) 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)~~(15) 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)~~(16) 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 clinic leadership with those of the hospital's lowest-paid employees who deliver health care services directly to hospital patients; and

(17) 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 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 the hospital exists within a network, ensure that hospital spending on network operations is consistent with the principles for health care reform expressed in section 9371 of this title or with the Statewide Health Care Delivery 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)(12) 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 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, patients affected by the proposed reduction or elimination of services, 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. In addition, a hospital shall notify affected patients about its proposed plan for transition of care, including information about the patient's rights concerning transfer of medical records.

(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 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 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.

(b) 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 Plan, once established.

(c) 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.

(d) The Board may recommend ~~or take appropriate~~ action as 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 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) ~~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.~~ 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 Plan; Health Care Delivery Advisory Committee * * *

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

§ 9403. STATEWIDE HEALTH CARE DELIVERY 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, and other interested stakeholders, shall lead development of an integrated Statewide Health Care Delivery 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) Promote access to high-quality, cost-effective acute care, primary care, chronic care, long-term care, 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.

(4) 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 preventive care services, which targets shall be aligned with the total cost of care targets.

(5) 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) such additional sources of data and information as the Board, Agency, and Department deem appropriate.

(6) Identify:

(A) gaps in access to care, as well as circumstances in which service closures or consolidations could result in improvements in quality, access, and affordability;

(B) opportunities to reduce administrative burdens, such as complexities in contracting and payment terms and 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.

(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.

(3) On or before January 15, 2029, the Agency shall present the Plan to the House Committees on Health Care and on Human Services and the Senate Committee on Health and Welfare.

(4) The Agency shall prepare an updated Plan every three years and shall present it to the General Assembly on or before January 15 every third year after 2029.

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

§ 9403a. HEALTH CARE DELIVERY ADVISORY COMMITTEE

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

(1) establish 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 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 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 independent physician practices, selected jointly by the Vermont Medical Society and HealthFirst;

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

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

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

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

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

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

(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.

* * * Data Integration; Data Sharing * * *

Sec. 10. 18 V.S.A. § 9353 is added to read:

§ 9353. INTEGRATION OF HEALTH CARE DATA

(a) The Agency of Human Services shall collaborate with the Health Information Exchange Steering Committee in the development of ~~n integrated system of clinical and claims data~~a Unified Health Data Space in order to

improve patient, provider, and payer access to relevant information and reduce ~~administrative burdens on providers.~~ system costs.

(b) The ~~Agency's process~~ development of the Unified Health Data Space by the Agency 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 aligned with the best privacy and security interests of patients;

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

~~(5)~~ (5) integrate clinical data, claims data, data regarding social drivers of health and health-related social needs, and other data types, or any subset thereof, only if a majority of the voting members of the Health Information Exchange Steering Committee votes that said integration should occur. As used in this subsection, the requirement that a majority of the Health Information Exchange Steering Committee votes to approve data integration means that a majority of voting members vote to approve a specific data

integration and not just a majority of a quorum of voting members that may be present at a given meeting;

(6) limit the use of integrated data approved per subsection b(5) to the use-restrictions established by the Health Information Exchange Steering Committee when they voted to approve the integration of said data;

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

~~(6)~~ (8) identify the resources necessary to complete data linkages for ~~clinical and~~ policy, health surveillance, population health management, research ~~usage;~~, and data integration uses approved by the Health Information Exchange Steering Committee pursuant to (b)(5) and (b)(6);

(~~7)~~ 9) establish a timeline for setup and access to the integrated system;

~~(8)~~ (10) develop and implement a system that ensures rapid access for patients, providers, and payers; ~~-~~and

~~(9)~~ (11) 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)~~(c) 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~~.~~ and subject to (b)(5).

~~(c~~ (d) 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.

(e) A representative of the Green Mountain Care Board shall be a voting member of the Health Information Exchange Steering Committee.

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

* * *

* * * 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.

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.

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 and maintain the Statewide Health Care Delivery 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 the effects of these efforts and activities on Vermonters and on Vermont's health care system.

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 of global hospital budgets, and the effects of these efforts and activities on Vermonters and on Vermont's health care system;

(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 * * *

Sec. 17. EFFECTIVE DATE

This act shall take effect on passage.

APPENDIX B

VERMONT LEGISLATIVE
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Fiscal Note

Updated April 24, 2025

Nolan Langweil, Principal Fiscal Analyst

S.126 – An act relating to health care payment and delivery system reform

As Passed by the Senate[1,i]

Bill Summary

The bill proposes to enact certain health care payment and delivery system reforms to promote the transformation of Vermont's health care system. The bill would:

- Direct the Green Mountain Care Board (GMCB) to implement reference-based pricing and establish standards for global hospital budgets;
- Require hospitals to disclose more information regarding executive compensation;
- Require the Agency of Human Services (AHS), in collaboration with GMCB, the Department of Financial Regulation (DFR), the Vermont Program for Quality in Health Care (VPQHC), the Office of the Health Care Advocate (HCA), and an advisory committee (also created in the bill) to develop an integrated Statewide Health Care Delivery Plan; and
- Require AHS to develop an integrated system of clinical and claims data.

Fiscal Impact

The bill as introduced by the Senate Committee on Health and Welfare included five new permanent positions and an appropriation of $1.5 million to GMCB and two new limited-service positions and an appropriation of $1.78 million to AHS. The bill as passed by the Senate did not include any positions or appropriations.

On April 23, the Senate Committee on Appropriations voted on an amendment to H.493 – An act relating to making appropriations for the support of government – which included appropriations in support of S.126 as passed by the Senate (on March 27, 2025). This included an appropriation of $2.5 million to the Agency of Human Services and an appropriation of $3.7 million to the Green Mountain Care Board, including 3 new positions. These appropriations are based on information provided by AHS and the GMCB for what they estimate are the resources needed to fulfill the work envisioned in S.126.

[1] *The Joint Fiscal Office (JFO) is a nonpartisan legislative office dedicated to producing unbiased fiscal analysis – this fiscal note is meant to provide information for legislative consideration, not to provide policy recommendations.*

Updated Fiscal Information - S.126	GF	HIT Fund	TOTAL
Agency of Human Services (AHS) - *Year One (half of stated need by AHS)*			
To support feasibility analysis and transformation plan development with hospitals, DA's, primary care organizations, and other community-based providers	$2,250,000		
To support development of quality and access measures, targets, and monitoring strategies for a statewide population health plan	$125,000		
To support development of hospital global budgets or other alternative payment models for Medicaid	$125,000		
TOTAL TO AHS	**$2,500,000**		**$2,500,000**
Note: AHS estimates the total need is $5 million. Chart above reflects one-year of funding.			
Green Mountain Care Board (GMCB)			
3 classified positions • Director, Reference-Based Pricing • Project Manager, Reference Based Pricing • Operations, Procurement, Contractual oversight	$512,500		
Contracts	$500,000		
Standardization of electronic hospital budget data submissions		$150,000	
TOTAL to GMCB	**$1,012,500**	**$150,000**	**$1,162,500**
TOTAL APPROPRIATIONS	**$3,512,500**	**$150,000**	**$3,662,500**

Appendix: Resources

- Green Mountain Care Board – 2024 Reference-Based Pricing and Data Analysis Report, in accordance with Act 113 of 2024, Sec. E.345.2. https://gmcboard.vermont.gov/Reference-Base-Pricing
- Vermont State Auditor – Strategies to Control the Rising Costs of State Employee Health Care: Investigative Report 21-07 (2021). https://auditor.vermont.gov/sites/auditor/files/documents/20211110%20%20State%20Employee%20Health%20Care%20Price%20Variation%20Report.pdf

[i] *The bill as introduced is available here:*

https://legislature.vermont.gov/Documents/2026/Docs/BILLS/S-0126/S-0126%20As%20Introduced.pdf

The full fiscal note history is available on the fiscal tab of the bill page on the General Assembly website and can be pulled up through a bill number search on the JFO page.