Jessica Holmes. S189. April 22, 2026 testimony

For the record, my name is Jessica Holmes and I am one of the GMCB members. Thank you for the invitation to testify on S189.

I thought what would be most helpful is to respond to what I think is your decision tree today.

So I think the first big question you face is: **does there need to be a state decision-maker, an entity that serves as the final arbiter of proposed service line changes?**

My answer -and I hope it is yours - is Yes. **State oversight over hospital service line reductions and eliminations is critical** if we want to ensure that access to care is preserved in the state. There should be an entity giving the "up or down" vote on service line changes – a decision-maker who is evaluating the impact of the proposed change on access, cost and quality across the whole system. If hospitals are left to decide on their own (which will happen with a non-binding recommendation from AHS), their decisions will ultimately be based on the impact to their hospital, to their bottom line, not to the system.

Given the fragility of the health care system and the financial headwinds the hospitals face, we should expect more service line closures. They are coming. Without state oversight, we will see health care deserts emerge for your family, your friends and your neighbors. For example, we could see the closure of more birthing centers. How will the closure of more birthing centers impact the cost of care? infant and maternal mortality rates in the state? our ability to attract young families to Vermont to lower tax burdens and ensure workforce? A state entity needs to take that holistic systemwide view and intervene when necessary.

A community open meeting or public hearing is not enough to ensure adequate access. It is necessary but not sufficient.

The Copley community had opportunity to comment and they still closed birthing. It might have been the right decision—but we don't know because there was never a systemwide analysis. Closure may have saved Copley money, but it may have also increased costs to the system—Copley births now delivered at UVM for example—they will show up in higher premiums and higher property taxes.

Closing Rutland's pediatric unit may have saved Rutland money but it likely would have added costs to the system to the extent acute pediatric patients would have been transferred to UVM. The hospital's plan did not include an assessment of local EMS capacity to make those transfers in a timely way, did not provide data analysis to show UVM could readily accept all or most acute peds patients, nor did it include an assessment of the additional cost to the patient, or to the system, of that ambulance transfer to Burlington or of being cared for at UVM instead of Rutland.

As a board member I can tell you if I had been forced to vote that day, I would have voted no to the closure—closing might have been the right decision but some of the financial analysis and volume data raised questions for me, there was no data suggesting quality was compromised, and most importantly there was no systemwide analysis on the cost, access or quality implications of the decision. Given their transformation responsibility, we asked for an assessment by AHS but did not get one. Without that analysis I could not, in good conscious, approve the closure of a pediatric inpatient unit, one of only few in the state, without full understanding of the consequences to the patients and the system. I would have said no -come back with a thorough analysis and we can reconsider. A "revise and resubmit"t if you will.

The Rutland peds closure would have been a hard decision, most service line changes are hard decisions—for the hospitals themselves and for any entity charged with the decision-making authority. And the GMCB does not shy away from hard or even unpopular decisions. We make them all the time. BUT to make them, we need the right information, and, in these service line cases we do not have the right information, nor did we have the resources to get it.

So, who does?

State review of service line changes is about ensuring that one hospital's financial decisions do not negatively impact access, quality, or costs elsewhere in the system.

AHS is uniquely qualified to make that systemwide assessment.

In fact, the Legislature has already entrusted this work to AHS. Through Acts 51 and 68, you charged AHS to lead the development of a statewide health care delivery system strategic plan; to coordinate transformation planning across providers and regions; to assess the impact of individual hospital transformation decisions on costs, premiums, access, and health outcomes; and to track whether those decisions collectively move Vermont toward lower costs, improved quality, reduced inequities, and increased access to essential services.

AHS is supposed to be driving transformation, not reacting to hospital-suggested transformation.

I would ask the committee to consider this: if you were the final decision-maker on service line changes, wouldn't you have a strong incentive to ensure the analysis underlying that decision was thorough and credible? Positioning AHS as the final authority on service line changes better ensures that the hospital transformation work and statewide strategic plan are developed with the highest level of rigor and accountability.

The legislature has already provided AHS with the resources to do that work—I believe more than $4 million in state funding for transformation alone this year.

And through the Feds RHT Program, AHS has just been awarded $1B over 5 years to lead the transformation of the health care delivery system.

For this year alone:

My understanding is that **AHS** is allocating **millions of dollars of those funds ($15m?)** to "hire a vendor to gather and study data that will inform hospital and regional transformation planning over the next five years and to **provide modeling to assess the impacts of proposed reforms on cost, quality, access, and sustainability across Vermont's hospitals and regions…**"

That is exactly the modelling needed to make the decision on whether a proposed service line change at one hospital harms access, cost, sustainability or quality in the system. The GMCB does not currently have the analytical capacity to do that work nor do we have the $15m to hire our own contractor.

My understanding is that **AHS** had planned to allocate another **$2.5m** to "hire a consultant to develop and implement a Statewide Health Care Delivery Strategic Plan for Vermont" that will "provide a **roadmap for health care delivery system reform**…**promote access to high-quality, cost-effective services across the system….and ensure a coordinated, data-driven approach to organizing and sustaining Vermont's health care delivery system statewide.**"

AHS is building the "roadmap" – the strategic plan---whether it is static or dynamic---you have already tasked them with designing the strategic plan that optimizes where hospital and other services should be provided - and now they have millions of dollars to do it.

Finally, my understanding is that **AHS** is allocating **$27m** of RHTF funds in transformation, innovation and regionalization support grants to "Support health care providers in **adopting tactical regional care strategies** that will shift appropriate services from hospitals to nonhospital settings and **create regional hospital services or centers of excellence**."

To responsibly award those grants. AHS will have to do the analysis to decide where those centers of excellence should be.

Note, doing the analysis to determine which hospital transformation efforts are worth funding and where there should be centers of excellence is exactly what S.189, as originally introduced in the Senate, asks AHS to do in the event of a proposed hospital service line closure or reduction.

***AHS is also a payer, and that matters.** Many of the essential, low-margin services we have seen on the chopping block—dialysis, birthing, primary care, pediatrics, mental health—depend heavily on Medicaid for financing. **If AHS determines that preserving access to certain services is necessary, doing so may require a targeted increase in Medicaid reimbursement, a stabilization grant, an enhanced payment in the Medicaid global budget, or another programmatic response. AHS is uniquely positioned to take those actions.**

S.189 as originally introduced aligns decision-making authority with existing statutory responsibility and resources. AHS is responsible for hospital and systemwide transformation, the statewide delivery system strategy, Medicaid, and other large portions of the care continuum (e.g., LTC, MH). AHS can and should decide if a service line change is optimal for the system.

The GMCB regulates hospital budgets. We can and should perform the regulatory function of adjusting an individual hospital's budget once a proposed service line change is reviewed and approved by AHS.

I want to add one more reason for AHS to give the "thumbs up or down" rather than the GMCB. It would be an incredible waste of taxpayer dollars to have GMCB duplicate the expenses associated with doing the analysis in order to make our own evidence-based service line decisions. It would also be counterproductive for the GMCB to come in and second guess AHS's strategic planning and transformation decisions. What happens if hospitals, AHS, and other healthcare providers work and expend huge resources on a vision for our delivery system and a regional transformation plan, only to then have GMCB come in at the 11th hour and chart a different path through a separate process? That makes no sense.

AHS leads transformation, always has, and deciding what service lines are where is a critical part of that responsibility.

I understand there may be some lingering other concerns:

1) Should it be Elimination AND Reduction of services or just Elimination? I think AHS needs to review both. If only elimination, a hospital can slowly reduce until the service is effectively gone. Death by a million cuts. Go from 6 inpatient psych beds to 4 to 2 to 0 over a period of couple of years and its effectively gone by the time the notification is made. Also, hospital board resolution of a service line reduction or closure as the trigger for an AHS review may not be strong enough—what if the reduction or closure is not brought before the hospital board?
2) Timing. I agree the language in the bill is unclear and may not provide enough time to do the work needed. I think Hospitals should notify the relevant parties at least 90-120 days before a proposed elimination or reduction. I would also add language to page 1 lines 13-17 that puts some onus on the hospital to take a "first pass" at assessing the systemwide cost, quality and access implications (e.g., in the Rutland case, it would have been nice to see their leadership make an attempt to understand the additional cost families would face with a transfer to UVM (both EMS transfer and higher cost per stay)). I think the Public Hearing should be held no less than 90 days before a planned closure. If AHS is deemed the final decision-maker, no closure happens until full analysis is done. If there is an analysis and a non-binding recommendation from AHS, it must be made within a certain time period as defined by the statute in order to be meaningful.
3) I think the bill is vague on what type of analysis should be done by AHS (whether for a nonbinding rec or an actual binding decision)- I think more explicit language should be added to the bill on page 2 lines 14-21. For example,

   Prior to approving any reduction or elimination of a hospital service line, AHS shall conduct a comprehensive analysis demonstrating the following:

Alignment with Statewide Strategy

The proposed change is consistent with the Health Care Delivery System Strategic Plan, the Community Health Needs Assessment, and ongoing hospital and regional transformation efforts.

Impact on Cost of Care

A quantifiable assessment of the impact on the cost of care for patients at that hospital and the broader health care system.

Impact on Access to Care

A quantifiable assessment of changes in access to care, including travel time, service availability, and whether alternative sites of care have sufficient capacity or are likely to experience increased wait times.

Impact on Quality of Care

A quantifiable assessment of the impact on quality of care, including whether alternative sites provide care of equal or higher quality.

Impact on Population Health

An evaluation of the potential effects on population health outcomes, including whether reduced access may delay care and adversely affect morbidity or mortality.

Network Adequacy

An assessment of whether the proposed change complies with applicable network adequacy standards.

Patient Transportation and Transfer Capacity

An evaluation of the adequacy of patient transfer and transportation systems, including emergency medical services capacity and the potential disproportionate impact on low-income populations without reliable transportation.

Consideration of Alternatives

Demonstration that all reasonable access-preserving alternatives have been considered and, where feasible, exhausted, including but not limited to Medicaid payment adjustments, stabilization funding, service-sharing arrangements, and other collaborative or transformational strategies.

4) I understand there may be questions about what happens after an AHS decision is made to keep a service line the hospital wanted to close. Are there ways to improve financial sustainability of that service line?

   I see two approaches: 1) First AHS can and should do an analysis of their Medicaid payments—is the Medicaid reimbursement adequately covering the cost of delivering that care? If not, AHS has the power to adjust payment if they deem this is a service that needs to stay in the community. That should be the first step. In the Rutland case, Rutland had not reached out to AHS prior to the hearing to explore the potential for enhanced Medicaid payments for the inpatient peds unit. That should have happened before closure proposed.

   2) Then it comes to GMCB for hospital budget review. First, we can adjust the budget to reflect the increase in the Medicaid revenue allocated to preserve that service. If there are still concerns about sustainability, the Board can look at commercial payment rates. This will be easier as we migrate to reference based pricing but for example, we could allow a targeted rate increase on that low margin service if AHS decides it must be saved in that community. Global budgets can also help ensure adequate funding for a prescribed portfolio of services. In other words, there are ways both AHS and GMCB can adjust revenues to make services more financially sustainable—but that only happens after holistic state review and oversight.

5) Finally, Emily Brown testified to this, but I would also eliminate item 3 on page 5. Not sure why DFR would suddenly play a role in monitoring the aftermath of service line decisions here.