Jessica Holmes. S189. February 26, 2026 testimony

For the record, my name is Jessica Holmes and I am one of the GMCB members. I am here on behalf of Chair Foster who could not be here today.

We support S.189 as introduced.

As originally written, **S.189 requires hospitals to provide <u>public notice</u> and <u>obtain approval from the Agency of Human Services</u>** before reducing or eliminating a service. If AHS grants that approval, the GMCB may adjust the hospital's budget accordingly.

My understanding is that there is broad agreement on the public notice requirement and on the importance of giving communities an opportunity to comment. We agree there should be public notice by the hospital.

The central question, is if, and which, state entity should have final approval authority.

First, I want to emphasize that the Board's position is that **state oversight over hospital service line reductions and eliminations is critical** if we want to ensure that access to high quality affordable care is preserved in the state. A community open meeting 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. Many births in the Copley service area are now probably happening at UVM---more expensive setting to give birth. Closure may have saved Copley money but it may have also increased costs to the system—which will show up in higher premiums and higher property taxes. Rutland's inpatient pediatric unit closure would likely have added costs to the system to the extent acute pediatric patients would have been transferred to UVM (the hospital's plan).

Financially strained hospitals will be tempted to close low margin services, services that many consider essential—birthing, mental health, pediatrics, and primary care. The financial headwinds are growing---sunsetting federal subsidies, shrinking commercial population, Medicaid changes…more reductions and eliminations are likely. **State oversight of these service reductions is in the best interest of Vermonters. If you vote to approve the amendment—where there is "notice" but no state oversight or approval, access will shrink, costs may go up, and there will be care deserts for your neighbors, family and friends. Please do not do that.**

So, who should approve these decisions?

S.189's approval standard is fundamentally about whether a proposed service line reduction is consistent with Vermont's health care delivery system strategy.

State review and oversight 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.

If the statutory test for approving service cuts is alignment with the State's delivery strategy and population needs, then the entity responsible for developing and stewarding that strategy should be the decision-maker.

The legislature has also provided AHS with the resources to do that work—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 **$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** is allocating 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.**"

Again, whether you call it innovation, transformation, or health system policy design, AHS is building the "roadmap" – you have already tasked them with designing the strategic plan that optimizes where hospital and other services should be provided - and they have millions of dollars to do it.

Finally, my understanding is that **AHS** is allocating **$27m** 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 allocate those taxpayer-funded grants in cost effective and impactful ways, AHS must evaluate and decide whether the proposed shifting of services will reduce cost, improve quality and retain access. The transformation grants should fund optimal transformation. To responsibly award those grants. AHS will have to do the analysis to make the decision about whether the proposed service adjustment will be beneficial to the state.

So again, adopting tactical regional care strategies and doing the analysis to determine which hospital transformation efforts to fund is exactly what S.189 as introduced asks AHS to do in the event of a proposed hospital service line closure or reduction.

The Board's position is that 1) State Review and Approval needs to happen and 2) that decision-making authority should sit with the entity that has both the statutory responsibility and the financial resources to assess systemwide impacts. AHS has access to over $45m in the next year alone to do the data analytics, transformation work, and system design. Over next 4 years, there will be more funding from the RHT program.

AHS is also a payer, and that matters. Many of the essential, low-margin services we are most concerned about losing—birthing, primary care, pediatrics, mental health—depend on Medicaid for sustainability. For some hospitals, a predominantly public payer mix is driving solvency issues. **If the State determines that preserving access to these 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. The GMCB neither pays for care nor administers funds.

In short, analysis and approval authority should rest with the entity that has both the statutory responsibility and the financial and programmatic capacity to evaluate systemwide impact and coordinate a response.

S.189 as introduced appropriately matches decision-making with institutional roles.

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). It 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 service change is approved by AHS.

Last note---**It would be incredibly wasteful of taxpayer dollars to have GMCB duplicate the expenses associated with doing the analysis required to make evidence-based service line decisions. It would add bureaucracy and waste and 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?

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

The statewide empirical analysis needed to evaluate whether one hospital's service line reduction or closure is in the best interest of Vermonters must include the following (at a minimum):

- Is this reduction or elimination consistent with the Health Care Delivery System Strategic Plan, the Community Needs Assessment, and ongoing regional transformation efforts?
- What quantifiable impact will this reduction or elimination have on the **cos**t of care for the residents of the hospital service area AND to the rest of the health care system? What quantifiable impact will it have on health insurance premiums, out of pocket costs, and property taxes?
- What quantifiable impact will this reduction or elimination have on **access** to care for the residents of the hospital's service area AND to the rest of the health

care system? Does the alternative site of care have excess capacity or will this change increase wait times at the receiving site?

- What quantifiable impact will this reduction or elimination have on the **quality** of care for the residents of the hospital's service area AND to the rest of the health care system? Is the alternative site of care of the same or higher quality?
- What quantifiable impact will this reduction or elimination have on population health (e.g., will closure delay access to care and therefore impact mortality rates?)
- What impact will this reduction or elimination have on network adequacy requirements?
- Is patient transfer to the proposed alternative site of care adequate (i.e., if EMS transfer is required, does the local EMS unit have excess capacity; if private transport is needed, will low income Vermonters without access to private transportation be disproportionately impacted?)
- Have all access-preserving strategies (increased Medicaid reimbursement, enhanced payments through Medicaid global budgets, stabilization grants, collaborative and transformational provider sharing agreements between entities, etc.) been exhausted?

The GMCB does not have the financial and staffing resources, data and analytics support to make those assessments.