

1 S.190

2 An act relating to reference-based pricing and the Green Mountain Care
3 Board

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

5 * * * Reference-Based Pricing * * *

6 Sec. 1. 18 V.S.A. § 9376(e) is amended to read:

7 (e) Reference-based pricing.

8 (1)(A) The Board shall establish reference-based prices that represent
9 the maximum amounts that hospitals shall accept as payment in full for items
10 provided and services delivered in Vermont. The Board may also implement
11 reference-based pricing for services delivered outside a hospital by setting the
12 minimum amounts that shall be paid for items provided and services delivered
13 by nonhospital-based health care professionals. The Board shall consult with
14 health insurers, hospitals, other health care professionals as applicable, the
15 Office of the Health Care Advocate, and the Agency of Human Services in
16 developing reference-based prices pursuant to this subsection (e), including on
17 ways to achieve all-payer alignment on the design and implementation of
18 reference-based pricing.

19 (B) The Board shall utilize reference-based pricing to reduce hospital
20 prices incrementally until they are equal to national median prices by hospital
21 type by calendar year 2030. The Board shall use the highest quality,
22 nonpartisan data demonstrating hospital prices as a percentage of Medicare to

1 evaluate progress toward reducing hospital prices in Vermont to the national
2 median.

3 (C) The Board shall implement reference-based pricing in a manner
4 that does not allow health care professionals to charge or collect from patients
5 or health insurers any amount in excess of the reference-based amount
6 established by the Board.

7 * * *

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

15 (B) The Board, in collaboration with the Department of Financial
16 Regulation, shall monitor the implementation of reference-based pricing to
17 ensure that any decreases in amounts paid to hospitals also result in decreases
18 in health insurance premiums. The Board shall post its findings regarding the
19 alignment between price decreases and premium decreases annually on its
20 website.

1 (C)(i) For provider contracts entered into, amended, or renewed on or
2 after January 1, 2028, each hospital and health insurer shall begin expressing
3 as a percentage of Medicare or of another benchmark, if another benchmark is
4 deemed appropriate by the Green Mountain Care Board, the rates for items and
5 services identified pursuant to a collaborative process between the Board and
6 representatives of Vermont hospitals.

7 (ii) When making public the charges for items and services
8 pursuant to 45 C.F.R. Part 180, each hospital shall include in its machine-
9 readable files pricing information shown as a percentage of Medicare rates, as
10 well as in dollars and cents, disaggregated by payer and by plan.

11 (iii) For purposes of subdivisions (i) and (ii) of this subdivision
12 (3)(C), a hospital may express rates as a percentage of Medicare based on the
13 actual reimbursement amounts the hospital receives from Medicare for items
14 provided and services delivered to Medicare beneficiaries until such time as
15 the Green Mountain Care Board adopts a rule establishing the methodology for
16 determining Medicare rates for use as a benchmark in establishing reference-
17 based prices pursuant to this subsection (e).

18 (D)(i) Each hospital shall apply for, obtain, and use a unique National
19 Provider Identifier (NPI) on all claims filed after October 1, 2027, for
20 reimbursement or payment of items provided and services delivered at an off-
21 campus department of the hospital that is distinct from the NPI used for

1 services delivered at the main hospital campus or at any other off-campus
2 hospital department.

3 (ii) As used in this subdivision (D):

4 (I) “Campus” has the same meaning as in 42 C.F.R. § 413.65.

5 (II) “Off-campus” means a facility located more than 250 yards
6 from the main hospital campus.

7 * * *

8 Sec. 2. LIMITATIONS ON HOSPITAL REIMBURSEMENTS FOR
9 QUALIFIED HEALTH BENEFIT PLANS AND PLANS
10 COVERING SCHOOL EMPLOYEES FOR HOSPITAL FISCAL
11 YEAR 2027

12 (a) As used in this section:

13 (1) “Health benefit association” has the same meaning as in 24 V.S.A.
14 § 4947.

15 (2)(A) “Medicare adjusted base rate” means the standardized Medicare
16 payment amount for a hospital inpatient, outpatient, or professional service as
17 determined under the Medicare program, calculated prior to the application of
18 any hospital-specific, patient-specific, or policy-based payment adjustments
19 and reflecting only the core payment methodology used by the Centers for
20 Medicare and Medicaid Services to establish baseline payment levels, which
21 include adjustments for geographic factors such as wages.

1 (B) For items provided and services delivered at a critical access
2 hospital, the Medicare adjusted base rate shall be determined under the
3 applicable Medicare prospective payment system, using the Medicare payment
4 methodology that would apply if the hospital were not designated as a critical
5 access hospital.

6 (3) “Qualified health benefit plan” has the same meaning as in
7 33 V.S.A. § 1802.

8 (4) “Registered carrier” has the same meaning as in 33 V.S.A. § 1811.

9 (5) “School employee” has the same meaning as in 16 V.S.A. § 2101.

10 (b) Notwithstanding any provision of 18 V.S.A. § 9375(b)(1)(A) to the
11 contrary, for hospital fiscal year 2027, the Green Mountain Care Board may
12 order hospitals to reduce their commercial reimbursement rates for qualified
13 health benefit plans and for health benefit plans offered to school employees
14 by a health benefit association pursuant to 24 V.S.A. § 4947 based on a
15 percentage of the Medicare adjusted base rate determined by the Board for
16 each item provided and service delivered in Vermont to enrollees in these
17 plans.

18 (c)(1) A registered carrier or health benefit association shall not reimburse
19 or agree to reimburse a hospital more than the percentage of the Medicare
20 adjusted base rate specified by the Green Mountain Care Board pursuant to
21 subsection (b) of this section, if any, for the applicable hospital fiscal year for

1 any item provided or service delivered in Vermont to an enrollee in a qualified
2 health benefit plan or a health benefit plan offered to school employees by a
3 health benefit association.

4 (2) In the event that a registered carrier or health benefit association
5 reimburses a hospital for an item or service on a capitated or other non-fee-for-
6 service basis, the carrier or association shall ensure that its reimbursement
7 method is adjusted to account for the reimbursement limit set forth in
8 subdivision (1) of this subsection.

9 (d) A hospital or hospital provider that is reimbursed in accordance with
10 subsections (b) and (c) of this section shall not charge or collect from the
11 patient any additional amounts other than the cost-sharing amounts authorized
12 by the terms of the health benefit plan.

13 (e) To the extent that a hospital is required by the Board's budget order to
14 reduce its commercial reimbursement rates by amounts greater than the
15 reductions achieved pursuant to subsection (b) of this section, the hospital shall
16 reduce its commercial reimbursement rates that exceed 500 percent of the
17 Medicare adjusted base rate or, if the hospital does not have any commercial
18 reimbursement rates that exceed 500 percent of the Medicare adjusted base
19 rate, by reducing its commercial reimbursement rates that are the highest in
20 relation to the Medicare adjusted base rate.

1 (f)(1) In its reviews of premium rates in accordance with 8 V.S.A. § 4026,
2 the Green Mountain Care Board shall ensure that the limitations on
3 reimbursements established in this section are appropriately reflected in the
4 premium rates for qualified health benefit plans.

5 (2) In its review of premium rates in accordance with 8 V.S.A. § 4026
6 and 24 V.S.A. chapter 121, subchapter 6, the Department of Financial
7 Regulation shall ensure that the limitations on reimbursements established in
8 this section are appropriately reflected in the premium rates for health benefit
9 plans offered to school employees by a health benefit association.

10 Sec. 3. [Deleted.]

11 * * * Hospital Outsourcing * * *

12 Sec. 4. HOSPITAL OUTSOURCING; HOSPITAL BUDGETS;
13 PROVIDER TAXES; REPORT

14 (a) For fiscal year 2027 hospital budgets, the Green Mountain Care Board
15 shall direct hospitals to provide such information as the Board may require
16 regarding the clinical services that the hospital outsources to external entities.

17 (b) On or before January 15, 2027, the Green Mountain Care Board, after
18 consulting with hospitals and their contracted independent providers and
19 assessing the impact of outsourcing on access to and the quality and
20 availability of care, shall provide findings and recommendations regarding
21 hospital outsourcing to the House Committees on Health Care and on Ways

1 and Means and the Senate Committees on Health and Welfare and on Finance.
2 In addition, the Board, in collaboration with the Agency of Human Services,
3 shall report on the extent to which hospital outsourcing affects provider tax
4 revenue and recommend any necessary modifications to 33 V.S.A. chapter 19,
5 subchapter 2 to appropriately reflect expenditures for patient care at Vermont
6 hospitals.

7 * * * Section 1332 Waiver for Reinsurance Program * * *

8 Sec. 4a. REINSURANCE; AUTHORIZATION TO PURSUE SECTION
9 1332 WAIVER

10 The Department of Vermont Health Access, in consultation with the
11 Department of Financial Regulation, is authorized to submit a State Innovation
12 Waiver pursuant to Section 1332 of the Patient Protection and Affordable Care
13 Act of 2010, Pub. L. No. 111-148, as amended by the Health Care and
14 Education Reconciliation Act of 2010, Pub. L. No. 111-152, to establish a
15 program for reinsurance and seek federal pass-through funding of amounts
16 attributable to premium tax credits under 26 U.S.C. § 36B.

17 * * * Excluding Reference-Based Pricing from Scope of Health Care

18 Professional Bargaining * * *

19 Sec. 5. 18 V.S.A. § 9409 is amended to read:

20 § 9409. HEALTH CARE PROVIDER BARGAINING GROUPS

1 (a) The Green Mountain Care Board may approve the creation of one or
2 more health care provider bargaining groups, consisting of health care
3 providers who choose to participate. A bargaining group is authorized to
4 negotiate on behalf of all participating providers with the Secretary of
5 Administration, the Secretary of Human Services, the Green Mountain Care
6 Board, or the Commissioner of Labor with respect to any matter in this
7 chapter; chapter 13, 219, 220, or 222 of this title; 21 V.S.A. chapter 9; and
8 33 V.S.A. chapters 18 and 19 with respect to provider regulation, provider
9 reimbursement, administrative simplification, information technology,
10 workforce planning, or quality of health care.

11 (b) The Green Mountain Care Board shall adopt by rule criteria for forming
12 and approving bargaining groups and criteria and procedures for negotiations
13 authorized by this section.

14 (c) The rules relating to negotiations shall include a nonbinding arbitration
15 process to assist in the resolution of disputes. Nothing in this section shall be
16 construed to limit the authority of the Secretary of Administration, the
17 Secretary of Human Services, the Green Mountain Care Board, or the
18 Commissioner of Labor to reject the recommendation or decision of the
19 arbiter.

20 (d) Notwithstanding any provisions of this section to the contrary, the
21 Green Mountain Care Board shall not be required to negotiate with a provider

1 bargaining group or engage in a nonbinding arbitration process in connection
2 with the Board's establishment of reference-based prices in accordance with
3 subdivision 9375(b)(1)(A), subdivision 9375(b)(5), or section 9376 of this title.

4 * * * Appeals of Green Mountain Care Board Orders * * *

5 Sec. 6. 18 V.S.A. § 9381 is amended to read:

6 § 9381. APPEALS

7 (a) The Green Mountain Care Board shall adopt procedures ~~for~~
8 ~~administrative appeals of its actions, orders, or other determinations. Such~~
9 ~~procedures shall~~ that provide for the issuance of a final order and for the
10 creation of a record sufficient to serve as the basis for judicial review of the
11 Board's final actions, orders, and other determinations pursuant to subsection
12 (b) of this section.

13 (b) Any person aggrieved by a final action, order, or other determination of
14 the Green Mountain Care Board may, ~~upon exhaustion of all administrative~~
15 ~~appeals available pursuant to subsection (a) of this section,~~ appeal to the
16 Supreme Court pursuant to the Vermont Rules of Appellate Procedure.

17 * * *

18 * * * Data Infrastructure * * *

19 Sec. 7. 18 V.S.A. § 9411 is amended to read:

20 § 9411. INTERACTIVE PRICE TRANSPARENCY DASHBOARD AND
21 HEALTH SYSTEM PERFORMANCE TOOL

1 (a)(1) The Green Mountain Care Board shall develop and maintain a
2 public, interactive, ~~Internet-based~~ internet-based price transparency dashboard
3 that allows consumers to compare health care prices for certain health care
4 services across the State. Using data from the Vermont Healthcare Claims
5 Uniform Reporting and Evaluation System (VHCURES) established pursuant
6 to section 9410 of this title, the dashboard shall provide the range of actual
7 allowed amounts for selected health care services, showing both the amount
8 paid by the health insurer or other payer and the amount of the member's
9 responsibility, and shall allow the consumer to sort the information by
10 geographic location, by health care provider, by payer type, and by the specific
11 health care procedure or health care service. The Board shall provide a link on
12 the dashboard to the statewide comparative hospital quality report published by
13 the Commissioner of Health pursuant to section 9405b of this title.

14 ~~(b)(2)~~ The Board shall update the information in the interactive price
15 transparency dashboard at least annually.

16 (b)(1) The Board shall develop and maintain a public, interactive tool that
17 displays information on health system performance, including information
18 regarding quality, access, and affordability.

19 (2) The Board shall update the information in the health system
20 performance tool on a regular basis, to the extent operationally feasible.

1 Sec. 8. IMPLEMENTATION OF HEALTH SYSTEM PERFORMANCE

2 TOOL

3 The Green Mountain Care Board shall develop the health system
4 performance tool described in 18 V.S.A. § 9411(b), as added by Sec. 7 of this
5 act, only if the Board receives sufficient funding from the federal government
6 or another source for this purpose.

7 * * * Critical Access Hospitals; Medicare Outpatient Cost Sharing * * *

8 Sec. 9. CRITICAL ACCESS HOSPITALS; MEDICARE OUTPATIENT
9 COST SHARING

10 (a) The General Assembly and the Green Mountain Care Board have
11 recently become aware of a federal requirement that Medicare beneficiaries
12 must bear financial responsibility for 20 percent of the amount charged for
13 outpatient services delivered by critical access hospitals, not 20 percent of the
14 amount that Medicare pays for the service. While the General Assembly
15 understands that it cannot invalidate this federal requirement, it also recognizes
16 both that this requirement has a significant, unfair, and negative financial
17 impact on Medicare beneficiaries in the State's most rural communities and
18 that Vermont's critical access hospitals are some of the State's most financially
19 vulnerable health care facilities. It is the intent of this section to provide
20 information to Vermont's seniors and other Medicare beneficiaries about the
21 federal requirement while a working group of interested stakeholders

1 endeavors to develop appropriate and enduring solutions that do not undermine
2 the financial sustainability of our critical access hospitals and that comply with
3 federal law.

4 (b) On or before September 1, 2026, each critical access hospital shall do
5 all of the following:

6 (1) Identify all the outpatient services for which the amount that the
7 hospital charges equals five or more times the Medicare allowed amount for
8 that service.

9 (2) Post prominently on its website and in outpatient departments of the
10 hospital a disclosure about the federal requirement that Medicare beneficiaries
11 must pay 20 percent of the charge for outpatient services at critical access
12 hospitals, that Medicare beneficiaries may be able to receive care with reduced
13 out-of-pocket costs from other providers, and how to contact the hospital's
14 patient financial assistance department for more information. The hospital
15 shall file its proposed disclosure materials with the Green Mountain Care
16 Board for the Board's approval prior to posting.

17 (c) To the extent that the Green Mountain Care Board engages in efforts to
18 address the Medicare outpatient cost-sharing issue in hospital fiscal year 2027,
19 the Board shall consider any proposals from the critical access hospitals and
20 other interested stakeholders and shall ensure that its actions are consistent

1 with ongoing hospital transformation efforts and the principles for health care
2 reform expressed in 18 V.S.A. § 9371.

3 * * * Effective Date * * *

4 Sec. 10. EFFECTIVE DATE

5 This act shall take effect on passage.