Act 68 Update on Hospital Reference-Based Pricing and Global Budgets

Act 68 – GMCB RBP Update

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 increasing access to care, improving the quality of care, and reducing the cost of care in Vermont.

Agenda

1. Requirements of Act 68
2. Hospital Reference Based Pricing
3. Hospital Global Budgets

Act 68 (2025)

Establish reference-based pricing (RBP) for hospital services by FY27

Review and monitor RBPs annually as part of GMCB's hospital budget review process

Identify conditions for modifications or termination of RBPs

Expand to non-hospital services (e.g. primary care)

Our Directive

The Vermont legislature passed Act 68 (2025):

Directs GMCB to **implement hospital reference-based pricing (RBP)** through its **provider rate setting authority, as soon as practicable**, but not later than hospital **FY27.**

The Problem: VT Hospital Prices

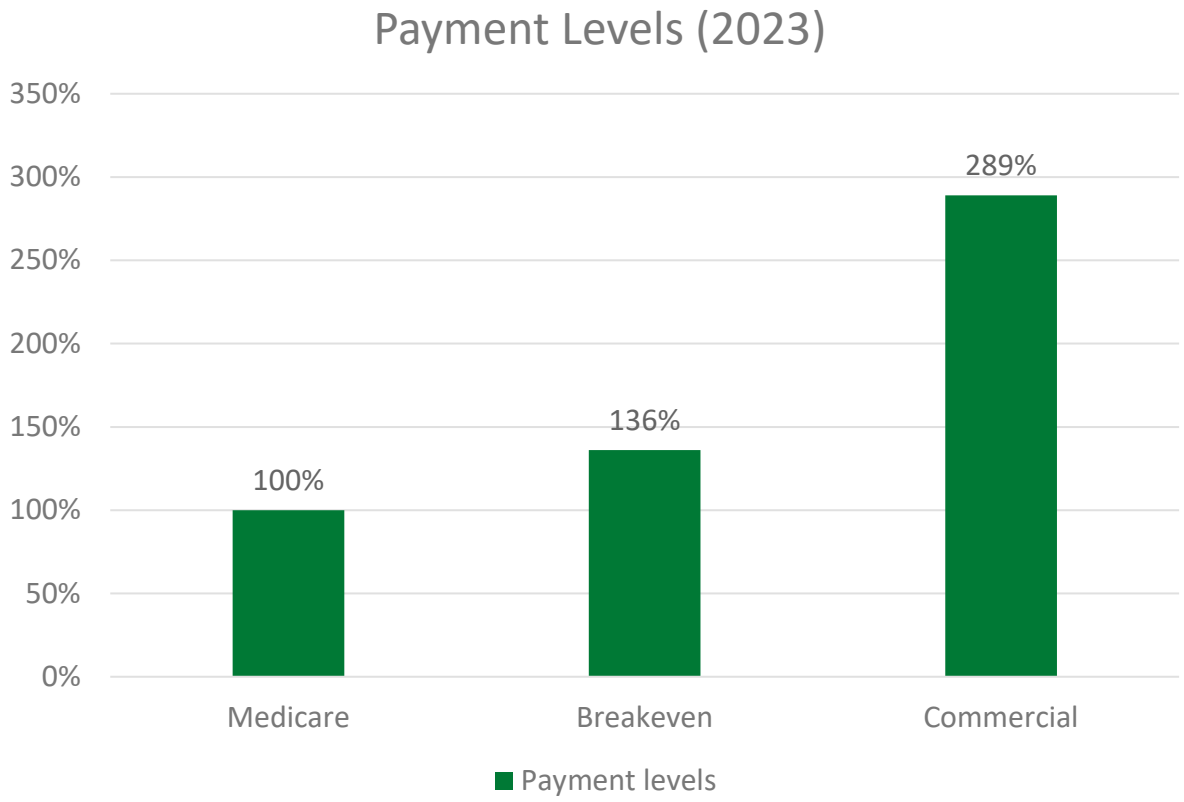


Figure 1: Payment levels received by Vermont hospitals, reflecting that hospitals charge commercial payers roughly 250%-300% of Medicare rates on average for inpatient and outpatient services. It should be noted that the breakeven point is approximately 136%.

- In VT, hospitals charge commercial payers **~250% - 300% of Medicare rates** on average, far above what is necessary to cover reasonable costs.
- Rising hospital prices translate directly into **premium increases** and higher out of pocket costs.
- Prices vary widely **within and across Vermont hospitals** for the same service, with no relationship to quality.

*Aggregated payment levels derived from the NASHP Hospital Cost Tool and the GMCB x HMA Reference-Based Pricing Report.
**Medicare rates are constructed to represent an approximate "break-even" payment rate for efficient hospitals.
***Breakeven, as shown above, represents the reimbursement rate commercial payers need to pay a hospital to cover all its costs, expressed as a multiple of the Medicare rate to show how much more commercial payers need to pay to ensure a hospital breaks even. (NASHP Hospital Cost Tool)

Commercial prices vary by Hospital as a % of Medicare

Outpatient Services

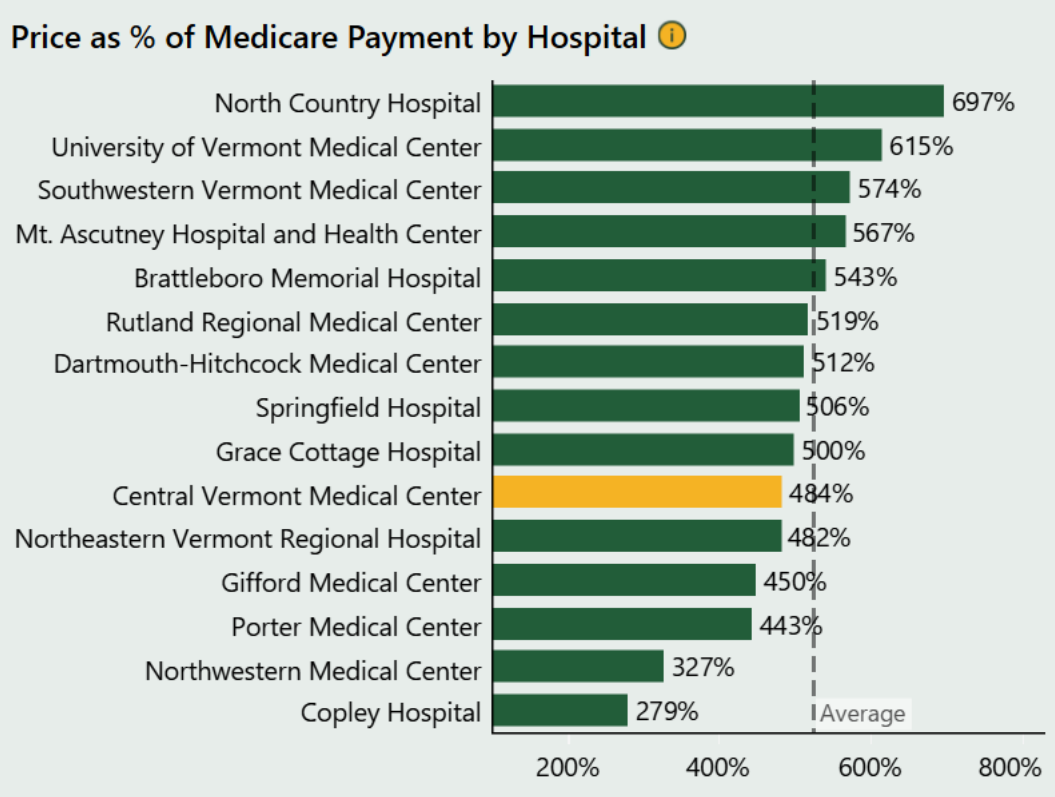


Figure 2: Horizontal bar chart showing commercial outpatient payments as a percentage of Medicare by hospital, ranging from about 279% to 697%, with five hospitals falling above the average reference line.

Inpatient Services

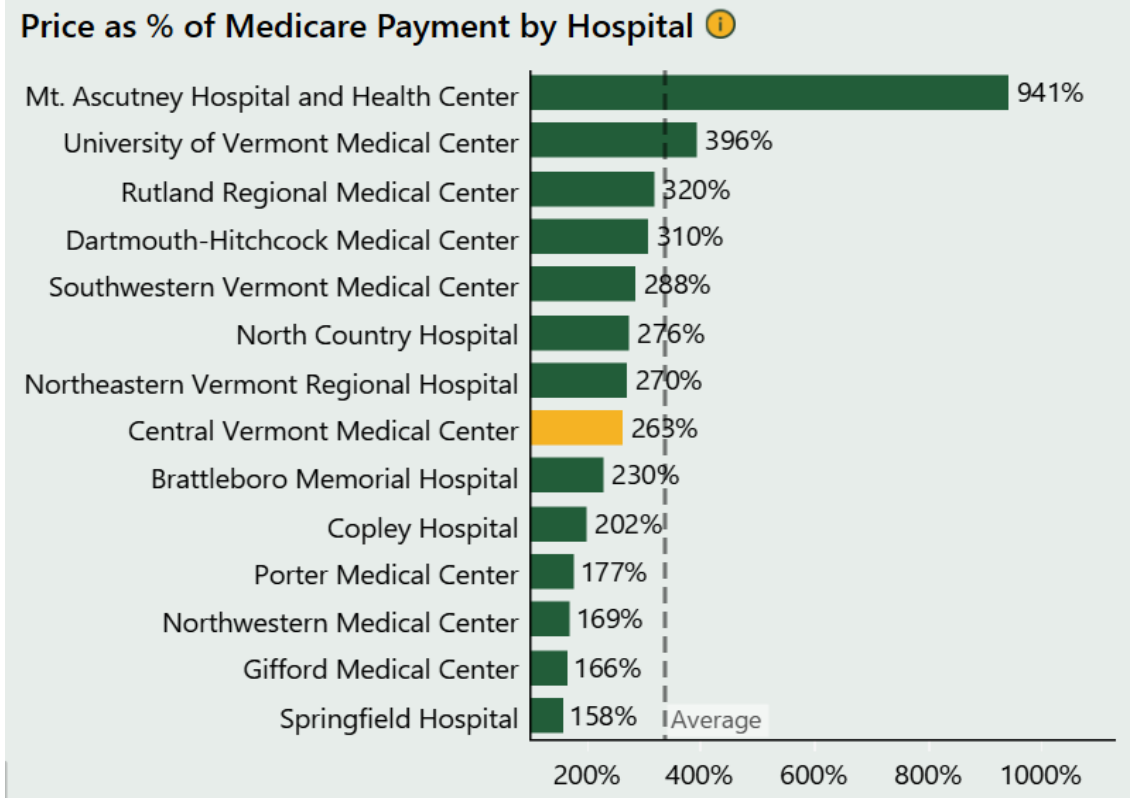
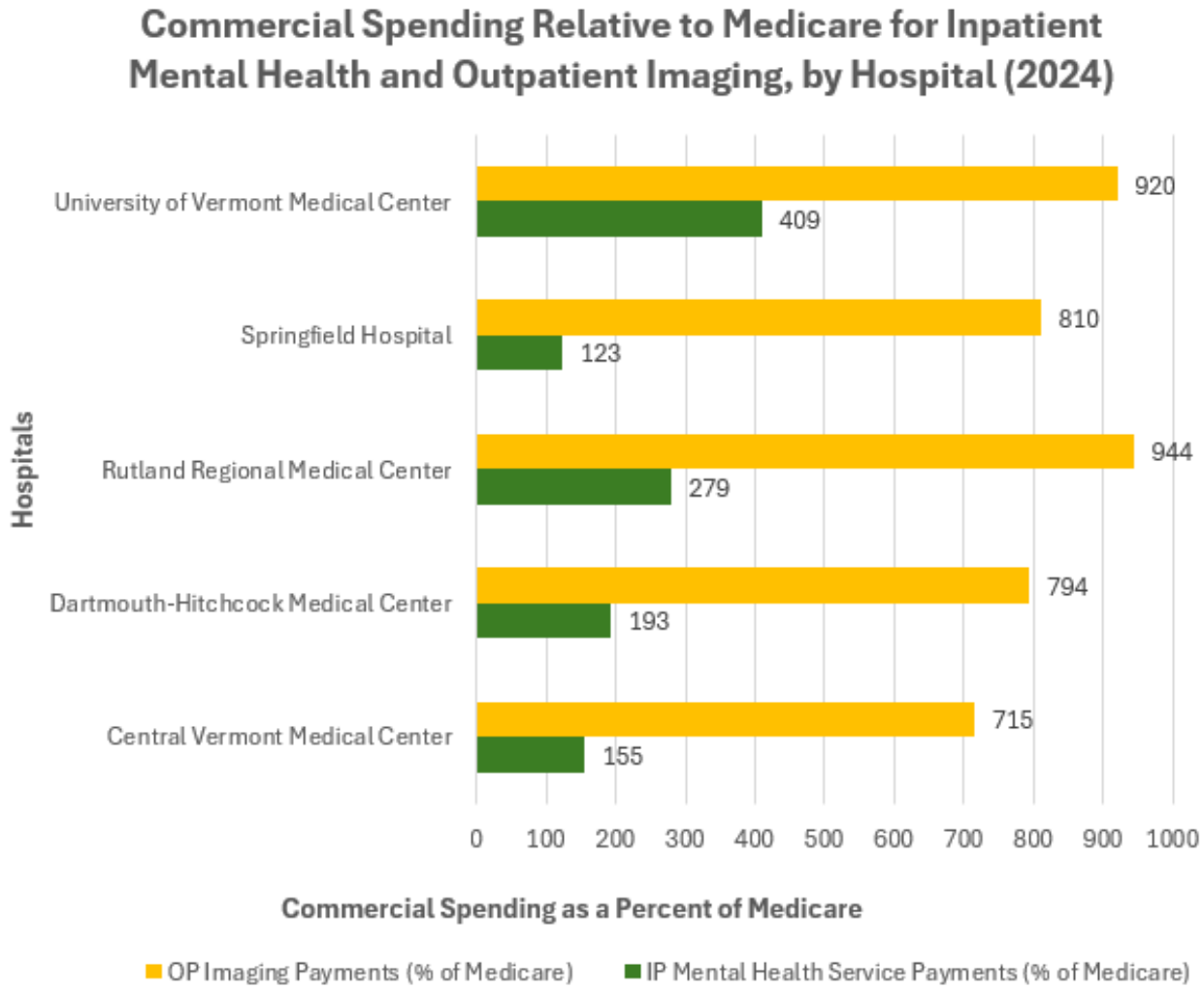


Figure 3: Horizontal bar chart showing commercial inpatient payments as a percentage of Medicare by hospital, ranging from approximately 158% to 941% of Medicare. Most hospitals cluster between 230% and 396%, with two hospitals falling above the average reference line. Mt Ascutney and UVM Health are the only facilities offering specialized inpatient rehab in VT.

Note: These data are snapshots from GMCB's forthcoming hospital price transparency tool based on 2024 claims data. Medicare defined as base price before any wage, geographic, policy, or patient-specific adjustment. Some price variation year to year for small hospitals may be disproportionally affected by fluctuations in service mix for the particular year.

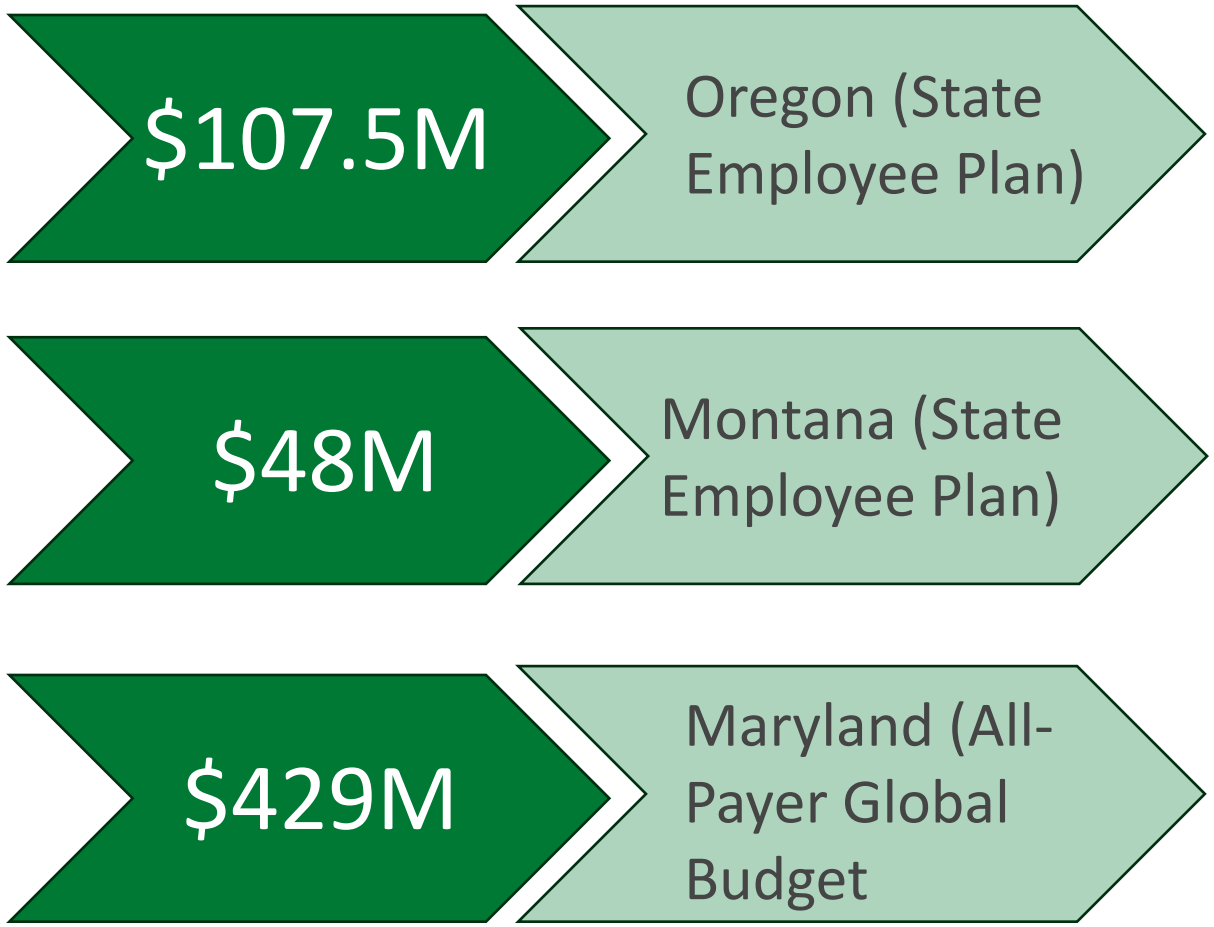
Prices Vary Within Hospitals & Across Service Lines



- Prices for inpatient and outpatient services vary wildly relative to Medicare **across hospitals and service lines**, with important considerations for selecting an RBP threshold.
- For example, outpatient imaging can reach up to 7–9× Medicare compared with 1–4× Medicare for inpatient mental health across hospitals.

Figure 4: Horizontal bar chart comparing commercial spending relative to Medicare for inpatient mental health services and outpatient imaging across five Vermont hospitals in 2024. For every hospital, commercial spending is higher for outpatient imaging, ranging from about 715% to 944% of Medicare, compared with 123% to 409% for inpatient mental health services.

The Solution: Fair Prices Vermonters Can Afford



- Average VT commercial payments ~289% of Medicare.
- At 200% of Medicare, VSEA + VEHI could have saved ~$400M (2018 – 2023), including $79M in 2022 alone.
- Ample room to rationalize prices without harming access or quality.

What Does RBP Do?

- Reduces hospital leverage to demand excessive prices
- Narrows unjustified price variation across hospitals
- Protects patient affordability
- Limits monopolistic pricing power
- Incentives operational efficiencies over price increases
- Acts as a necessary input for systemic payment and delivery reform

What Does RBP Not Do?

- Does not set prices across the system
- Does not alone control total hospital spending (volume)
- Does not alone guarantee savings, nor that they are passed to consumers (without explicit targets & oversight)
- Does not inherently restructure incentives around prevention or care delivery
- Does not guarantee hospital efficiency/sustainability or quality performance

Cross-State Differences in Design

Program	Distinct Features
Vermont Act 68	Mandatory statewide reference-based **maximum allowable payment rates** applied through GMCB's rate-setting authority for all Vermont hospitals; methodology set by rule in 2027, effective HFY28.
Oregon (2019)	State employee plan only; 200% in-network / 185% out-of-network cap; exemptions for rural/CAHs; savings >$100M in first 27 months.
Montana (2016)	State employee plan; direct contracting at % Medicare; initial success ($48M savings) but politically fragile without statutory mandate.
Washington (2021)	Public option ("Cascade Care"); capped hospital reimbursement at 160% of Medicare for participating networks; voluntary participation; expanding to state employee plans.
Maryland Global Budgets (2014 – Present)	All-payer system; only provider-side rate-setting model; hospitals receive **fixed annual revenue** based on standardized prices and volume expectations; includes Medicare waiver; strong incentives to manage population health and quality.

Table 1: Table titled "Cross-State Differences in Design" comparing hospital payment reforms across states. Rows summarize Vermont Act 68, Oregon, Montana, Washington, and Maryland, highlighting differences in scope, use of reference-based pricing or rate caps tied to Medicare, participation requirements, and reported outcomes such as savings or global budget structures.

Phased Approach

Phase I – Differential Hospital Price Growth (Hospital Budget Guidance)

Policy Scan
(Sept-Oct 2025)

Public Comment
(Jan 2026)

(Dec 2025)
Develop Policy Options & Model Impact

(Mar 2026)
FY27 HBR Guidance

Timelines are Contingent Upon:

1. **Expedient, smooth contracting processes, and**
2. **No major challenges in developing data infrastructure.**

Phase II – Hospital Referenced Based Pricing (Rate Setting)

Discovery & Design
(Aug '25- Aug '26)

Report to Legislature on Implementation Update
(Feb '26)

FY28 Rate Setting Guidance & HBR Guidance
(Mar '27)

(Aug '26 – Dec '26)
Model Baseline, Policy Options & Data Validation

Policy & Regulatory Development
(Jan '26– Jan '27)

Figure 5: Horizontal timeline labeled "Phased Approach," showing Phase I milestones from 2025 to 2026 (policy scan, public comment, and guidance development) and Phase II milestones from 2025 to 2027 (discovery and design, modeling and validation, legislative update, and rate-setting guidance).

Rationale for Phased Approach

- Policy
  - Balances early affordability gains with health system stability
  - Statewide approach reflecting varying community needs and hospital role in the system
  - Borrowing best practices, localizing solutions, consider stakeholder input
  - Ensure adaptable to evolving environments, avoid unnecessary disruption, ensure long-term sustainability
- Operational
  - Rule-making and stakeholder engagement for rate-setting
  - Competitive procurement (Bulletin 3.5)

GMCB work to date to rationalize hospital prices

Though rate setting is still getting off the ground, GMCB has made significant efforts through regulatory action to reduce hospital prices relative to national trends:

		FY26 Commercial Revenue ($M)
VT Legislature	Act 55, Outpatient drug cap	-$104.30
Green Mountain Care Board	Hospital Budget Orders	-$94.58
	Hospital Budget Enforcement	-$31.76
		-$230.65

Table 2: Table showing FY26 commercial revenue reductions totaling -$230.65 million, including -$104.30 million from Act 55 outpatient drug cap, -$94.58 million from hospital budget orders, and -$31.76 million from hospital budget enforcement.

Preview of FY 2027 Hospital Budget Review

Growth benchmarks recommended by staff for FY2027 Hospital Budget Guidance:

Commercial Rate: -1%

Commercial NPR: -1%

Operating Expense: 0%

**Benchmarks are not final until the Board adopts guidance (on or before March 31)*

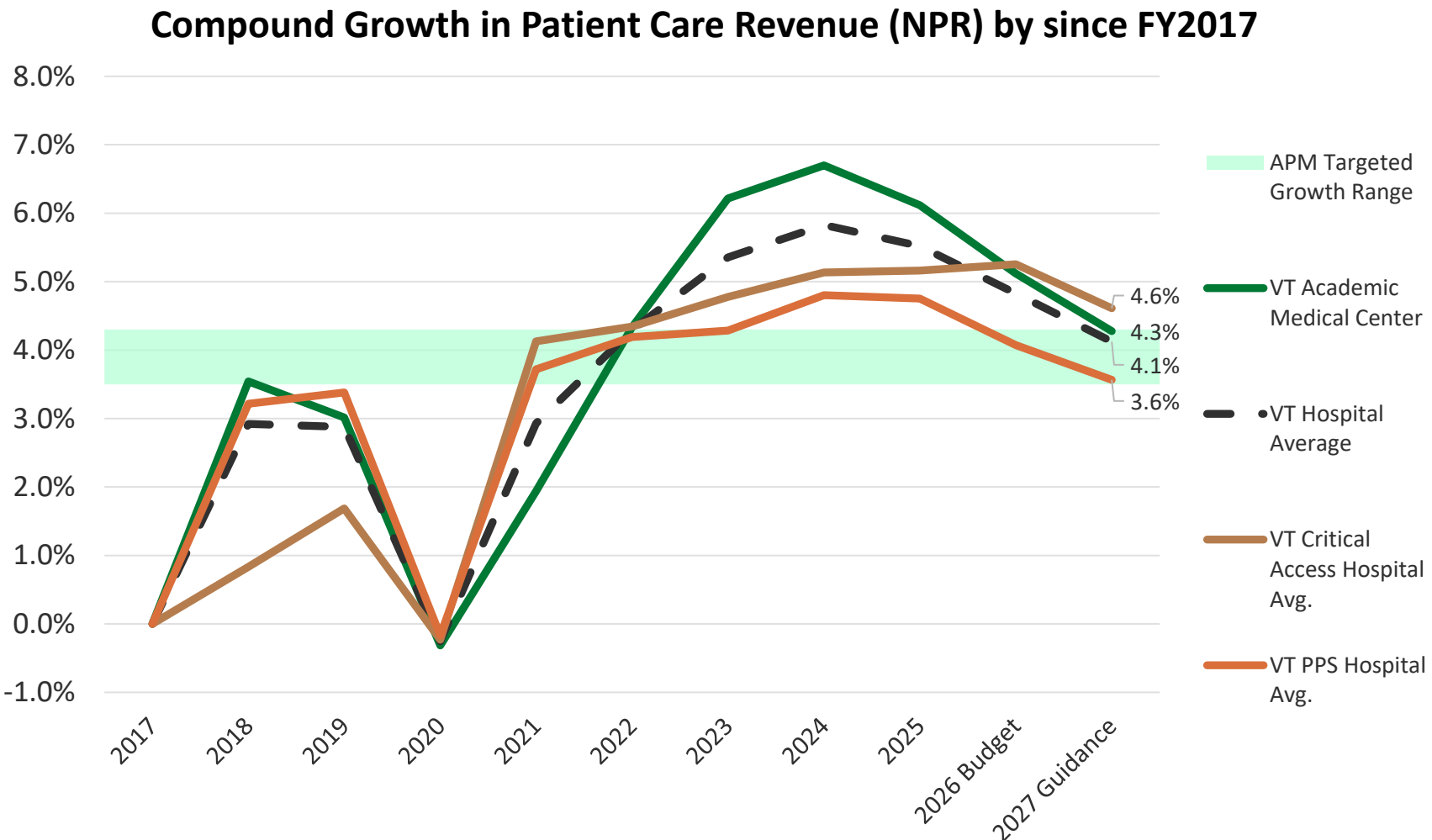


Figure 6: Line graph showing Vermont hospital patient care revenue growth since FY2017, with a dip in 2020, peak above the 3.5–4.5% APM target range in 2023–2024, and decline toward the target by 2027 guidance; FY2027 benchmarks include -1% commercial rate and NPR growth and 0% operating expense growth.

RBP in FY 2027 Hospital Budget Review

GMCB to establish systemwide and hospital commercial revenue reduction targets through benchmarks in FY2027 HBR guidance.

GMCB recommends legislative language to require hospitals' application of any commercial revenue reductions to "outlier services" i.e. highest priced and volume of services.

Legislative language could target immediate savings to health plans with the greatest affordability concerns by establishing an aggregate cap on hospital commercial prices at 200% of Medicare (e.g. QHP, VEHI, VSEA) from an insurer perspective (no insurer shall pay more than X%).

Activities to Date

Fall 2025 – Winter 2026:

- Hired Affordability and Pricing Project Director
- Initial Stakeholder Discussions, Capacity Building, and Public Presentations (e.g., Primary Care Steering Committee)
- Brown University Analysis of VT's Medicare Payment Landscape
- RFP Development to support program design and impact modeling
- Policy Development and State-to-State Engagement
- FY27 Hospital Budget Guidance Development
- Review of existing data

December 2025

- RFP Released

January 2026

- RBP & Medicare Payment 101 Speaker Series (Event 1)
- RFP Bids Received (Currently Under Review)

February 2026

- Update to legislature on Act 68 (this report)
- Publish Price Transparency Dashboard (First Release Forthcoming)

Important Insights to date…

Key driver of affordability is high prices for hospital care

Strive for methodological simplicity and predictability to guard against regulatory capture or failure

Base price – best approach for apples-to-apples across hospitals, and reduces noise from Medicare-specific policy adjustments

CAHs reimbursed differently

Comprehensive approach ensures no squeezing of the balloon: i.e. apply methods in aggregate and at the service level

RBP does not prevent against volume gaming, requiring complementary approach (e.g. hospital global budgets)

Here's where we are thinking about going

- Medicare adjusted base rate to allow apples to apples approach across hospitals
- Not one-size fits all (e.g. CAH adjustment, glide-path for financially distressed hospitals)
- Other considerations we are exploring
  - How to best integrate RBP into hospital budget review?
  - How to monitor adherence to price caps?
  - How best to incentivize competition on quality and quality improvement?
  - How to ensure regulatory alignment with insurance rate review?
  - How to best support transformation and preserving access to essential services?
  - Conditions for termination or modification?

Up Next

March 2026: RBP Vendor Selection & FY2027 Hospital Budget Guidance

April/May 2026: Rate-Setting and RBP Discussion Draft Release

Spring 2026 – Winter 2027: RBP Modeling, Methodological Development, and Stakeholder Engagement

Summer 2026 – Winter 2027: Rate-Setting Rulemaking

March 2027: Final RBP Methodology Released for FY28 Hospital Budget Guidance

Background: Act 167 & Act 68

Act 167 (2022): Required the GMCB (in collaboration with AHS, and stakeholders) to develop value-based payments including global payments for Vermont hospitals that would

1. Help move hospitals away from fee-for-service
2. Provide hospitals with predictable, sustainable funding that is aligned across multiple payers, sufficient to enable the hospitals to deliver high-quality, affordable health care services to patients
3. Is consistent with the principles of health care reform (18 V.S.A. § 9371)

Act 68 (2025): requires GMCB to establish a global hospital budget for non-critical access hospitals by 2028 and for all Vermont hospitals by 2030.

Hospital Global Budgets

What? A prospective budget set in advance for a hospital to deliver services to a defined population, typically determined by formula rather than volume of services provided.

Why? Controls total hospital spending while reducing incentives for unnecessary utilization inherent in fee-for-service payment; serves as a complement to rate setting approaches that control price, by limiting the volume of services delivered.

Total spending = Price x Volume

Hospital Global Budgets

How is a HGB designed/calculated?

- **Scope**: Which services are included vs. excluded (e.g., capital, outpatient care, high-cost drugs)
- **Population adjustment**: How budgets account for patient demographics, complexity, and socioeconomic factors
- **Volume treatment**: Whether and how budgets adjust for changes in patient volume
- **Quality linkage**: Integration of performance metrics or outcomes into budget levels
- **Flexibility mechanisms**: Provisions for mid-year adjustments, carryover of savings, or risk corridors

Key tradeoffs: Greater cost control vs. potential access restrictions; administrative simplicity vs. sophisticated risk adjustment; flexibility for hospitals vs. predictability for payers.

History of Hospital Global Budgets in VT

Approach	Detail	Year
GMCB Regulation (Current)	Establishes cap on net patient revenue (NPR) hospitals can receive.	2012
Rutland Regional Medical Center Pliot	GMCB to establish payments for hospital based on historical revenue with inflation, adjusting for patient demographics (not implemented).	2014
Vermont All Payer ACO Model	Voluntary commercial payer/provider participation in hospital global payments aligned across Medicare, Medicaid, and Commercial based on historical spend, reconciled to FFS equivalent.	2017-2025
Act 167/Act68	Directs GMCB to continue pursuing design and implementation of hospital global budgets.	2022 to present

Table 3: Table titled "History of Hospital Global Budgets in VT" listing four approaches: GMCB Regulation (2012) establishing a cap on net patient revenue; Rutland Regional Medical Center Pilot (2014) proposing payments based on historical revenue (not implemented); Vermont All-Payer ACO Model (2017–2025) aligning global payments across payers; and Act 167/Act 68 (2022–present) directing GMCB to continue hospital global budget design and implementation.

Work to date on Hospital Global Budgets (HGB) in Vermont (Act167/Act68)

	Medicare	Medicaid	Commercial
AHEAD 1.0 (Biden Admin.)	VT Designed HGB (GMCB)	Vermont designed hospital global budget (DVHA) **Beginning Jan 2026**	Vermont designed hospital global budget (GMCB) **TBD***
AHEAD 2.0 (Trump Admin.)	CMS FFS HGB Methodology + Med Adv **Jan 2028 (Cohort 2)**		
No AHEAD	CMS Traditional FFS + Med Adv		

*Direction for GMCB to implement hospital global budgets is contingent on provision of necessary resources at the Board.

Table 4: Table comparing Medicare, Medicaid, and Commercial hospital global budget approaches in Vermont under AHEAD 1.0, AHEAD 2.0, and No AHEAD, including CMS FFS methodology starting January 2028 for Medicare, Vermont-designed Medicaid HGB beginning January 2026, and commercial HGB listed as TBD; implementation contingent on Board resources.

What's next?

- Is Vermont going to participate in AHEAD?
- How can Vermont strike the right balance of simplicity vs. precision in controlling hospital spending, i.e. hospital global budgets?

**GMCB Hospital global budget statutory requirement is predicated on receipt of necessary resources*

Discussion

Thank You!

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Accessibility Requests

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