Reference-Based Pricing (Sec. 1)

Goals

To add clarification on the expected methodology for calculating hospital pricing information as a percentage of Medicare rates.

Language

Unless and until GMCB's hospital RBP rule is established, include an interim definition of the "Medicare base" as the "Medicare Adjusted Base Rate," meaning the standardized Medicare payment amount for a hospital inpatient, outpatient, or professional service as determined under the federal Medicare program, calculated prior to the application of any hospital-specific, patient-specific, or policy-based payment adjustments, but reflecting the geographic-based adjustments used by the Centers for Medicare and Medicaid Services (CMS) to establish baseline payment levels. For services furnished by a Critical Access Hospital, the Medicare Adjusted Base Rate shall be determined as though the service were paid under the applicable Medicare prospective payment system, using the Medicare payment methodology that would apply if the hospital were not designated as a Critical Access Hospital.

Consider modifying language of new 18 V.S.A. § 9376(e)(C) to ensure it captures all contracts: "For provider contracts entered into, amended, or renewed on or after October 1, 2026 . . . ."

Targeting Board-Ordered Hospital Rate Reductions to High Priced Services (Sec. 1)

Goals

To improve affordability of Vermont healthcare by bringing Vermont's high hospital prices more in line with national norms. Prior to the adoption of a rate setting rule, Vermont can properly improve hospital prices through a phased approach to reference-based pricing by utilizing the Green Mountain Care Board's existing regulatory authorities while a full reference-based pricing program for Vermont hospitals is developed and implemented.

Language

(a) Until the Green Mountain Care Board establishes and implements a full reference-based pricing methodology for Vermont hospitals in rule:

(1) a hospital shall implement any commercial rate reduction ordered by the Board pursuant to 18 V.S.A. § 9456 by first reducing its commercial rates that exceed five hundred percent of the Medicare adjusted base rate or, if the hospital does not have any commercial

rates that exceed five hundred percent of the Medicare adjusted base rate, by first reducing its commercial rates that are the highest in relation to the Medicare adjusted base rate; and

(2) hospitals shall not increase any commercial rate that exceeds two-hundred and fifty percent of the Medicare adjusted base rate.

(b) For purposes of this section, the "Medicare adjusted base rate" means the standardized Medicare payment amount for a hospital inpatient, outpatient, or professional service as determined under the traditional Medicare program, calculated prior to the application of any hospital-specific, patient-specific, or policy-based payment adjustments, and reflecting only the core payment methodology used by the Centers for Medicare and Medicaid Services to establish baseline payment levels, including adjustments for geographic factors such as wages. For services furnished by a Critical Access Hospital, the Medicare adjusted base rate shall be determined under the applicable Medicare prospective payment system, using the Medicare payment methodology that would apply if the hospital were not designated as a Critical Access Hospital.

Hospital Reference Based Prices for Qualified Health Plans (Sec. 1)

Goals

To complement the reference-based pricing authority of the Green Mountain Care Board under 18 V.S.A. § 9376(e) by establishing binding payment limits on carriers that issue qualified health plans in Vermont, and to ensure that resulting reductions in hospital payments translate into corresponding reductions in qualified health plan premiums.

Language

Sec. X. Title 33, Chapter 18, Subchapter 1 is amended by adding a new section to read:

§ 1815. HOSPITAL REIMBURSEMENT

(a) A registered carrier shall not, for any item provided or service delivered in Vermont to an enrolled member of a health benefit plan, either reimburse or agree to reimburse a hospital more than two-hundred and fifty percent of the Medicare adjusted base rate.

(b) For purposes of this section, the "Medicare adjusted base rate" means the standardized Medicare payment amount for a hospital inpatient, outpatient, or professional service as determined under the traditional Medicare program, calculated prior to the application of any hospital-specific, patient-specific, or policy-based payment adjustments, and reflecting only the core payment methodology used by the Centers for Medicare and Medicaid Services to establish baseline payment levels, including adjustments for geographic factors such as wages. For services furnished by a Critical Access Hospital, the Medicare adjusted base rate shall be determined under the applicable Medicare prospective payment system, using the Medicare payment methodology that would apply if the hospital were not designated as a Critical Access Hospital.

(c) The reimbursement limit in subsection (a) of this section shall apply until the Green Mountain Care Board establishes reference-based prices under 18 V.S.A. § 9376(e).

(d) In the event a registered carrier reimburses a hospital for an item or service that is subject to the reimbursement limit in subsection (a) of this section on a capitated or other non-fee-for-service basis, the carrier must ensure that the reimbursement method it uses is adjusted to account for the reimbursement limit in subsection (a).

(e) A hospital or hospital provider that is reimbursed in accordance with subsection (a) of this section may not charge to or collect from the patient or from a person who is financially responsible for the patient any additional amounts other than cost sharing amounts authorized by the terms of the health benefit plan.

(f) The purpose of this section is to reduce health care costs. A hospital shall not increase the amounts the hospital charges for prescription drugs, procedures, tests, imaging, or other health care goods or services in an effort to offset revenue reduced as a result of this section.

Excluding GMCB Functions from Provider Bargaining Group Requirements

Goals

To exclude Green Mountain Care Board functions from the requirements of 18 V.S.A. § 9409.

Language

Sec. 8. 18 V.S.A. § 9409 is amended to read:

§ 9409. HEALTH CARE PROVIDER BARGAINING GROUPS

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

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

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

Health System Performance Tool (Sec. 11)

Goals

To clarify the full scope of the health system performance tool and updating expectations.

Language

Sec. 11. 18 V.S.A. §9411 is amended to read:

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

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

(2) The Board shall update the information in the health system performance tool on a regular basis as operationally practical.