VERMONT
GREEN MOUNTAIN CARE BOARD

GMCB written comments in response to committee markup discussion on February 26, 2026

This document responds to the Senate Health & Welfare Committee's February 26, 2026, markup discussion on S.189 and S.190 and questions you posed to GMCB.

S.189

We support the bill as originally proposed. Changes to share or split service line approval decisions between AHS and GMCB will increase administrative cost and waste, lead to delay, and increase confusion at a time when Vermont's healthcare system desperately needs clear transformation leadership and vision.

AHS has requested—and received—not only authority from the Legislature to lead transformation, but enormous fiscal resources to execute that responsibility. It is illogical and wasteful for AHS to perform only part of the job, particularly given that AHS will necessarily make decisions in connection with allocating Rural Health Transformation Program (RHTP) funding and determining which hospital transformation projects receive state support and technical assistance that substantially overlap and parallel service line review decisions.

- **AHS already has clear statutory authority to oversee and ensure health system transformation is executed in the public interest**, as outlined in Act 51 and Act 68.
- **AHS has been awarded significant resources to support transformation**. In this year alone, AHS received more than $4 million in state funding and has been awarded more than $1B over 5 years to support transformation - with $45 million specifically available next year for analytic support for health system transformation. Service line decision-making ***is*** transformation and artificially carving it out harms Vermont. Service line reviews cannot be properly performed without resources, and a decision-making entity needs to lead, direct, and control the analytic component that feeds decisions. Moreover, having GMCB perform service line review until 2028 is illogical as GMCB still would not have the resources for the task and GMCB's decisions very well could conflict with AHS's transformation vision and plans – which would lead to further waste, delay, and create system confusion.
- **As the Medicaid administrator in Vermont, AHS has a responsibility to ensure access to care for our most vulnerable Vermonters**. Many of the essential, low-margin services we are most concerned about losing—birthing, primary care, pediatrics, mental health—depend on Medicaid for sustainability. Having service line review with AHS connects Medicaid policy to transformation and closely couples the important considerations necessary to design a sustainable healthcare system. GMCB does not control Medicaid and having GMCB perform service line reviews without control of the critical lever that is Medicaid payment policy is not beneficial.

If the Committee is determined not to have transformation *and* service line decision-making together at AHS, at a minimum it must move the financial and human resources to GMCB so that the analytics and decision-making are together. Moreover, the Committee should require AHS to use its resources and state-wide vision and planning to provide clear recommendations to GMCB on AHS's perspectives on proposed service line changes, including through submission of written position papers, and testimony before GMCB as to AHS's views and transformation goals as they relate to service line changes before GMCB.

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S.190

Sec. 1 (adding (C) and (E) to 18 V.S.A. § 9376(e)(3)): Medicare-Referenced Contracting

We support the language as originally proposed[1] because it supports payer and provider readiness for hospital reference-based pricing caps and prevents further delay of this critical program. GMCB's proposal related to this section included two distinct components:

1. **MANDATORY MEDICARE-REFERENCED CONTRACTING.** Require hospitals and health insurers to execute[2] contract rates as a percentage of Medicare for all services. This creates a standardized baseline for rate negotiations and enables meaningful price comparisons across payers.
2. **ENHANCED PRICE TRANSPARENCY REPORTING.** Require hospitals to report all pricing in machine-readable transparency files as a percentage (and in dollars and cents) of Medicare rates, disaggregated by payer and plan. This allows regulators, employers, and consumers to identify pricing disparities and market inefficiencies.

Importance of the "percentage of Medicare" requirement in provider contracting

1. Begins moving hospitals and payers off of contracts based on discounts off charges and into comparable units.
2. This is the minimum viable infrastructure for RBP implementation until full implementation in FY28. Striking this provision of S. 190 could risk delaying implementation of reference-based pricing caps and our efforts to improve healthcare affordability.
3. This advances fairness and accountability in a space where no one is ensuring prices are fair.

Right now, Vermont's commercial hospital contracting is largely discounts off charges (chargemaster-based). That structure is notoriously opaque and hospital-specific: two hospitals can both say "60% off charges" and still be vastly different in real price because the underlying "charges" are arbitrary, secretive, and untethered from the true costs of providing that service.

Requiring that rates be based on a percentage of Medicare is advantageous because payers and employers will understand what they're buying, GMCB can appropriately evaluate reasonableness and pricing variation, and the market can function with common language. This is the same approach as taken in Oregon's public payer program, which requires provider contracts to be expressed as a percentage of Medicare and still allows for negotiation below the cap.

It is infeasible (and poor governance) for GMCB to post the prices for each hospital.

1. Medicare/CMS does not "post prices" either – Medicare administers a methodology, which aligns with GMCB's envisioned approach.
2. Centralized posting would create a legal and operational risk for the State.

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[1] GMCB previously suggested a minor modification to the language in paragraph (C) to clarify that the requirement would apply to existing provider contracts, not just new contracts.

[2] GMCB suggests that paragraph (C) would be clearer if, instead of requiring hospitals and insurers to express rates as a percentage of Medicare in their contracts, they be required to *contract for* those rates on the basis of Medicare.

3. The staffing and IT infrastructure requirements are disproportionate to the policy objective (rate-setting unit prices is a different policy model, which is possible someday, but that's not what this section is trying to do now).

Medicare does not post prices; they maintain a methodology for reimbursing hospitals for services they provide. It is important to remember that the GMCB's hospital reference-based pricing program will be implemented through a series of hospital price caps. **This program is not meant to establish a specific price for each hospital and service.** Payers and providers are still expected to negotiate prices underneath the cap. Having transparency of what payers and providers have negotiated is an essential input to monitoring and ensuring compliance in this program.

Importance of GMCB's Medicare Adjusted Base Rate Language

We recently proposed language that would establish an interim definition for the Medicare adjusted base rate consistent with anticipated staff recommendations for the full implementation in FY28. This statutory definition can sunset once the GMCB adopts its hospital reference-based price rule.

1. "Percent of Medicare" is meaningless unless everyone is using the same definition.
2. Without specifying an approach for CAHs, we will get unusable data and results.

This is exactly why experts at the GMCB's RBP-focused Board meeting on January 28, 2026 recommended measuring commercial price as a percentage of the Medicare base rate, enabling an apples-to-apples comparison of Vermont hospitals and avoiding distortions from federal policy adjustments and retrospective reimbursements, cost settlements, audits, and true-ups.

Sec. 2: Hospital Outsourcing

We support the language as initially proposed, which ensures that all hospital spending remains subject to the Green Mountain Care Board's regulatory oversight. This provision is essential to preventing further cost-shifting and the escalation of health care expenses, particularly through arrangements with for-profit entities such as private equity-owned provider groups and practices.

The magnitude of GMCB's return on investment depends, in significant part, on its ability to address the key drivers of health care costs. When revenue falls outside the Board's purview and is not subject to the same revenue and price limitations, it erodes the State's investment in cost containment and diminishes the impact that hospital reference-based pricing can have on affordability. Permitting regulatory bypass also risks creating a bifurcated system in which different providers operate under fundamentally different incentives, to the detriment of patients and the public interest.

We want to be clear: We are not advocating for banning outsourcing. Outsourcing can be an important and appropriate business tool when it enables more efficient or higher-quality delivery of care to Vermonters. What this language is designed to ensure is that all providers of hospital services are subject to the same rules and incentives, so that cost and quality standards apply consistently, regardless of the contractual or corporate structure through which care is delivered.

Scope and Definition

The GMCB has received examples from hospitals illustrating how outsourcing arrangements currently operate in practice. While there are some services that are commonly outsourced and expected - for example, imaging reads, especially after hours - we have learned there are less commonly outsourced services that have implications for our regulation and assessments. For example, if a hospital that contracts for emergency department clinicians but does not directly bill for those services, the associated revenue for that service will likely not be reflected on that hospital's financial statements. These examples underscore the importance of clear definitional language to ensure the provision captures the full range of arrangements it is intended to reach, and to avoid ambiguity that could invite circumvention.

"(a) Definitions. As used in this section, "outsourcing" means an arrangement in which a hospital contracts with an external entity that assumes sole control of direct clinical care offered within the hospital facility and the revenue from the provision of the care is not included in the net patient revenue of the hospital. "Outsourced services" may include emergency medicine, anesthesiology, hospitalist services, and other direct patient care services provided on-site at the hospital by a contracted entity. "Outsourced services" do not include services provided by a nurse on a short-term contract with a hospital in which the hospital retains oversight and control over patient care; off-site diagnostic services, including off-site diagnostic interpretation of radiologic images and off-site laboratory testing; or nonclinical services such as laundry services, nutrition services, information technology, or cybersecurity."

Sec 6-8. Repeal of Health Care Provider Bargaining Group Authorizing Language

While excluding reference-based pricing from the reach of the provider bargaining group statutes will address an immediate concern, we still strongly believe that the policy reflected in these statutes is problematic and we look forward to future opportunities to explain why these statutes should be repealed or significantly revised.