CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health BROWN UNIVERSITY

Analysis of Medicare Final Payment Rates in Vermont

AUTHORS:
Roslyn Murray, PhD, MPP, Nathan Hostert, MPA, Christopher Whaley, PhD

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I. Introduction

Under Vermont's recently enacted Act 68 of 2025, the Green Mountain Care Board (GMCB) is directed to establish reference-based price caps for hospitals "based on a percentage of the Medicare reimbursement for the same or a similar item or service or on another benchmark, as appropriate." Act 68 grants the GMCB the authority to determine how these price caps are structured, in consultation with health care stakeholders.

Other states, including Oregon and Washington, have adopted Medicare-based price caps that benchmark commercial payments to what Medicare would have paid for the same service if the patient were a Medicare beneficiary. In both states, benchmarks are based on the final Medicare payment amount, including the base payment and all applicable add-ons and adjustments. Consistent with this approach, our analysis uses hospital data and Medicare payment formulas to compare final Medicare payments at Vermont prospective payment system (PPS) hospitals with those at PPS hospitals nationally for a standardized inpatient admission.

We find that average Medicare inpatient payments to PPS hospitals in Vermont—excluding critical access hospitals (CAHs)—exceed the national average, ranking 9th among 49 states and Washington, D.C. These higher payment rates are largely driven by Vermont PPS hospitals receiving greater add-on payments and adjustments than hospitals in other states.

This memo was produced by economists at the Center for Advancing Health Policy through Research (CAHPR) at the Brown University School of Public Health. CAHPR is a nonpartisan center dedicated to generating research that informs policies aimed at reducing costs, improving patient well-being, and driving meaningful transformations in U.S. health care delivery.

II. Data

We used data from the Centers for Medicare and Medicaid Services' Fiscal Year (FY) 2023 Final Rule Inpatient Prospective Payment System (IPPS) Impact File ("Impact File") to calculate Medicare's IPPS payments to PPS hospitals, excluding CAHs. We examined hospitals with data reported in the Impact File, which includes hospitals paid under IPPS. We excluded hospitals in Maryland because they are paid based on hospital global budgets. Our resulting sample included 3,117 PPS hospitals in 49 U.S. states and Washington, D.C.

III. Methodology

Final Medicare payments consist of the "base" payment rate for an inpatient service, plus add-on payments for teaching programs, hospitals serving large numbers of low-income patients, or hospitals located in remote areas, as well as adjustments tied to quality performance. To compare Medicare payments for a similar patient case, we used a Medicare Severity Diagnosis Related Group (MS-DRG) weight of 1 (i.e., the national average patient and procedure case-mix) and assumed no transfers, outlier payments, or other case-specific adjustments. Using the Impact File, we calculated the base rate and final payment for PPS hospitals nationwide (Figure 1).

First, we adjust the FY 2023 federal standardized operating rate ($6,142.33) and capital rate ($483.79) for geographic factors. A portion of the operating rate is adjusted by the local wage index (i.e., 67.6% of the rate is adjusted if the wage index is greater than 1, or 62% of the rate is adjusted if the wage index is less than or equal to 1). The capital rate is adjusted by the geographic adjustment factor and hospitals in Hawaii and Alaska receive a cost of living adjustment. The operating rate is also adjusted based on whether the hospital submits quality data and is a meaningful electronic health record (EHR) user (i.e., 3.8% increase if yes to both, 0.725% increase if yes to quality data only, 2.775% increase if yes to EHR only, and 0.3% reduction if no to both). Both of the operating and capital rates are adjusted for case mix using MS-DRG weights (we used a standardized weight of 1). The base rate is the sum of the adjusted operating and capital rates.

Next, we calculate hospital-specific add-ons and adjustments based on certain hospital characteristics—including whether the hospital is a teaching hospital, serves a high share of low-income patients, or is located in a remote area—and quality performance. Teaching hospitals receive indirect medical education (IME) payments to cover the indirect costs of patient care associated with training residents. Hospitals that treat a higher share of low-income patients receive disproportionate share (DSH) and uncompensated care payments. Sole community hospitals (SCHs)—hospitals located more than 35 miles from the nearest acute care hospital or are considered "isolated"—have the potential to receive higher operating payments (i.e., hospital-specific payments [HSPs]) if the cost per admission in a base year, updated to the current year and adjusted for case mix, is higher than what they would have received under the IPPS. For our analysis, we represent these payments as the difference between the HSP for SCHs and the operating base rate. Hospitals can also receive bonuses or penalties based on their performance on a set of outcomes, patient experience, and safety and efficiency measures or if they have excess readmissions.

There are also adjustments for transfers, outliers, and other pass-throughs that we did not account for in our calculations.[1] The final IPPS payment is the sum of the base rate and the hospital-specific add-ons and adjustments.

IV. Results

Vermont ranks 28th among 49 states and Washington, D.C., for both average wage index (0.963) and average base rate ($6,704.40)—slightly below the national average base rate of $6,908.90 (Figures 2 & 3). This is not surprising, given that the base rate is strongly correlated with the local area wage index. However, Vermont ranks notably higher for final IPPS payments, placing 9th nationally with an average payment of $9,396.00 (Figure 4). Vermont's average final IPPS payment exceeds the national average of $8,525.70.

Final payment rates for PPS hospitals in Vermont are composed primarily of base rates (71.4 percent), with a substantial share of add-on payments and adjustments (28.6 percent) (Figure 5). Only one state has a higher share of add-ons and adjustments. Vermont's add-on payments and adjustments are primarily driven by large hospital specific payments and IME payments. On average, Vermont PPS hospitals receive the fourth-highest HSPs nationwide (Figure 6).

Figure 7 shows that Vermont PPS hospitals have base rates and final payments comparable to PPS hospitals in Maine and New Hampshire. Figure 8 shows that final IPPS payments for a standardized case at UVM are similar to other peer academic medical centers, and Figure 9 shows that final IPPS payments for a standardized case at other Vermont PPS hospitals are similar to those at peer mid-sized community hospitals.

Implementing a commercial price cap at 200% of the Medicare final IPPS payment would result in substantially greater variation in the maximum price that could be paid across Vermont PPS hospitals than a cap based on 275% of the Medicare base rate (Figure 10).

V. Alternative Benchmark Setting: Using Average Medicare Payments per DRG

A previous analysis conducted by the Advisory Board used Medicare claims data to examine average Medicare payments per case in Vermont, offering an alternative methodology for

[1] Medicare Payment Advisory Commission. Hospital Acute Inpatient Services Payment System. MedPAC; 2024. [Link]

benchmarking to Medicare. However, this approach is not standard in other state benchmark initiatives, which instead reference what Medicare would have paid for that exact case, had the commercial patient been a Medicare beneficiary. Using a claims-based approach (as the Advisory Board did), Vermont hospitals appear to have the lowest average Medicare payments per DRG across the country for almost half of the DRGs (Appendix Figure 1).

There are multiple reasons why average Medicare payments per DRG may influence the comparison between Vermont and other states. For example:

- *Transfer cases*: Medicare reduces payments when a patient is transferred to another hospital. When a patient is transferred to another short-term acute care hospital more than one day prior to the geometric mean length of stay for the DRG, the hospital is paid a per diem rate. These lower payments are baked into the average payment per DRG, even though a commercial plan might pay in full for a similar case. Vermont has the highest share of inter-hospital transfer cases in the U.S., resulting in lower average Medicare payments per DRG than other states (Appendix Table 1).
- *Excludes some add-ons*: Claims do not include certain add-on payments that hospitals receive and thus claims are lower than actual final Medicare payments. For example, uncompensated care payments and value-based payment bonuses or penalties are not captured in claims. Vermont has among the highest share of add-on payments in the U.S. (Figure 5).

In contrast, the standard approach (outlined in section III of this report) allows for the manual application of case-specific adjustments, such as transfer reductions or outlier payments, based on the specifics of the commercial case. This flexibility allows for a more apples-to-apples comparison, where both the commercial price and the Medicare benchmark reflect the same patient and service characteristics, rather than relying on aggregate averages that may not be relevant to the case in question. Compared to using average Medicare payments per DRG, the standard approach would result in a higher commercial price cap if set at the same percentage of Medicare (see example below).

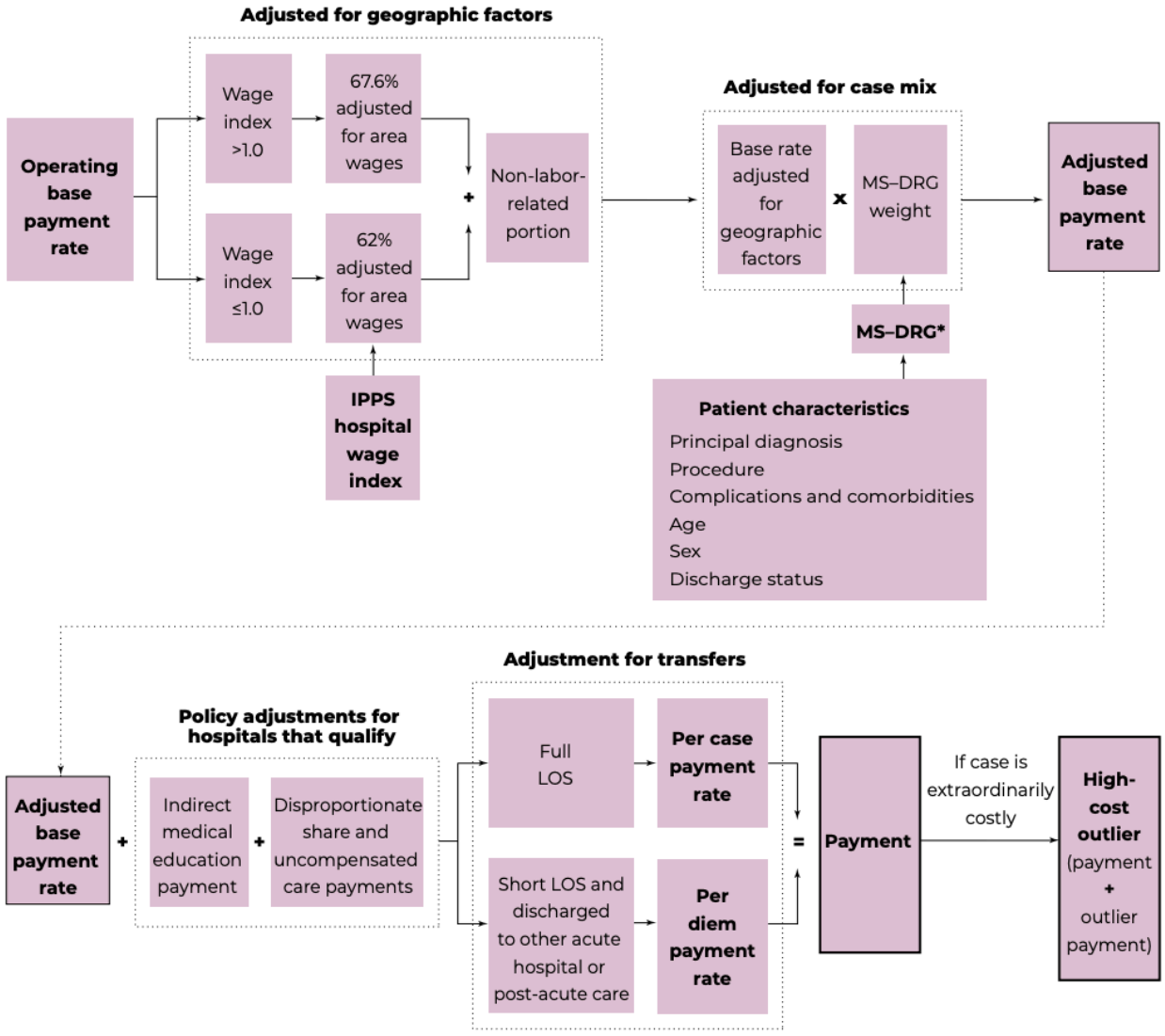
Example. DRG 871 (Septicemia or Severe Sepsis without MV >96 hours with Major Complications)

	Average Medicare Payment per DRG	**Standard Approach**
Medicare Benchmark	$12,079	$18,390
200% of Medicare Benchmark	$24,158	$36,780

Notes: Average Medicare payments per DRG are lower than the standard approach due to the influence of transfer cases, outliers, and the exclusion of certain add-on payments and adjustments. To calculate the standard Medicare payment for the commercial case, we multiplied the average final payment in Vermont ($9,396) *by the 2023 DRG weight for MS-DRG 871 (1.9572).*

VI. Figures

Figure 1. Medicare IPPS payments.



Source: Medicare Payment Advisory Commission. Hospital Acute Inpatient Services Payment System. MedPAC; 2024. [Link]

Figure 2. Average hospital wage index by state.

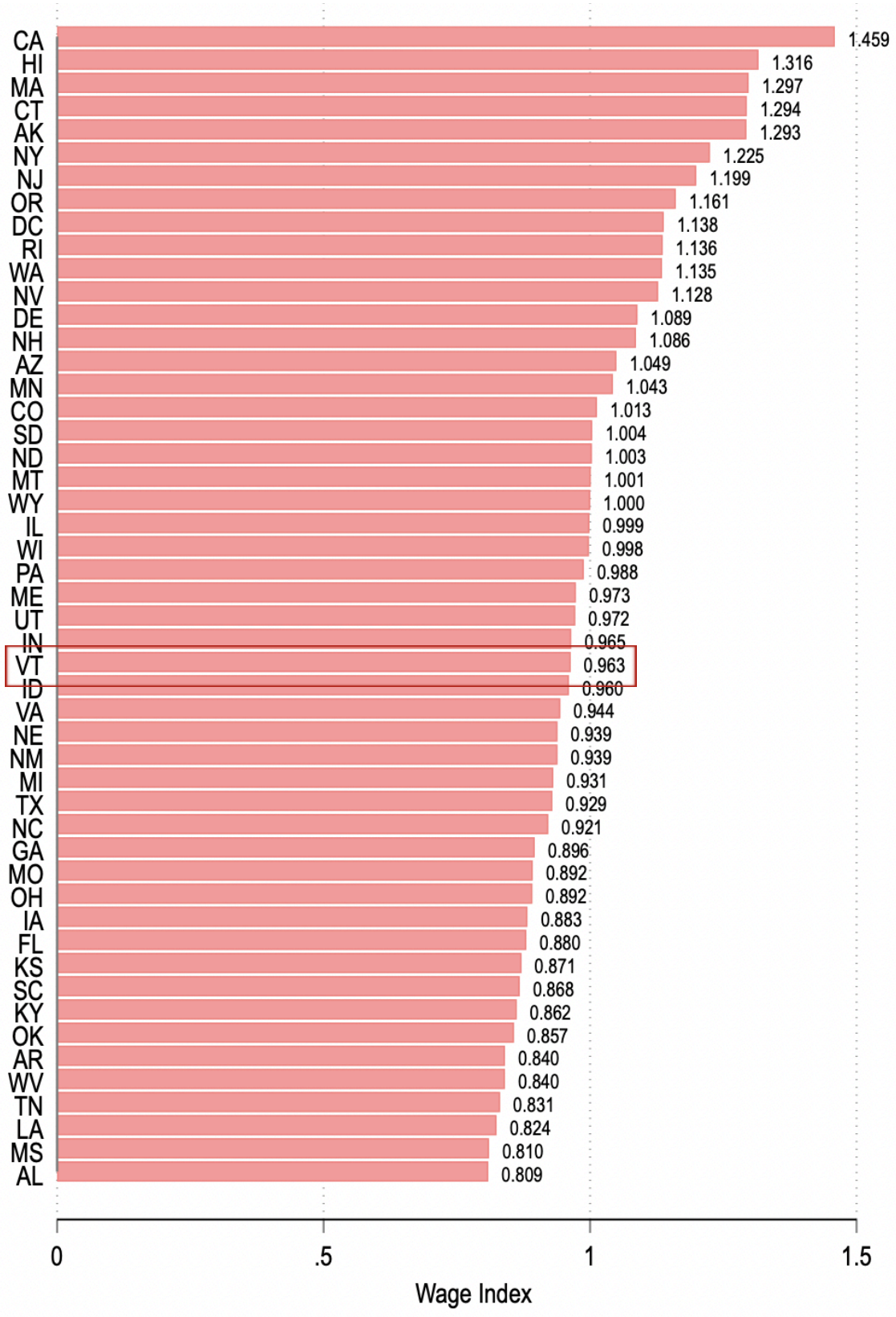


Figure 3. Average Medicare base rate by state.

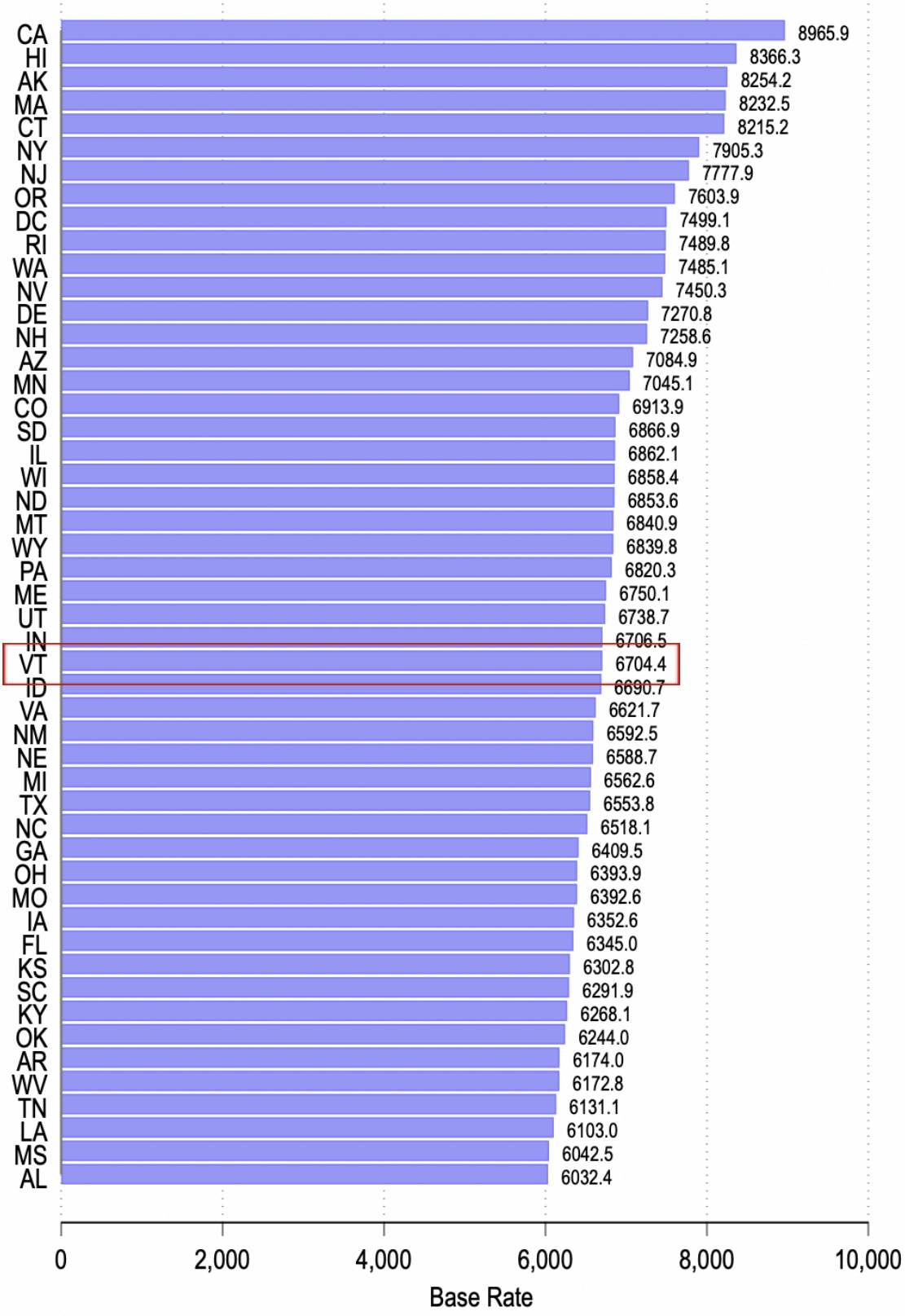


Figure 4. Average Medicare final IPPS payment by state.

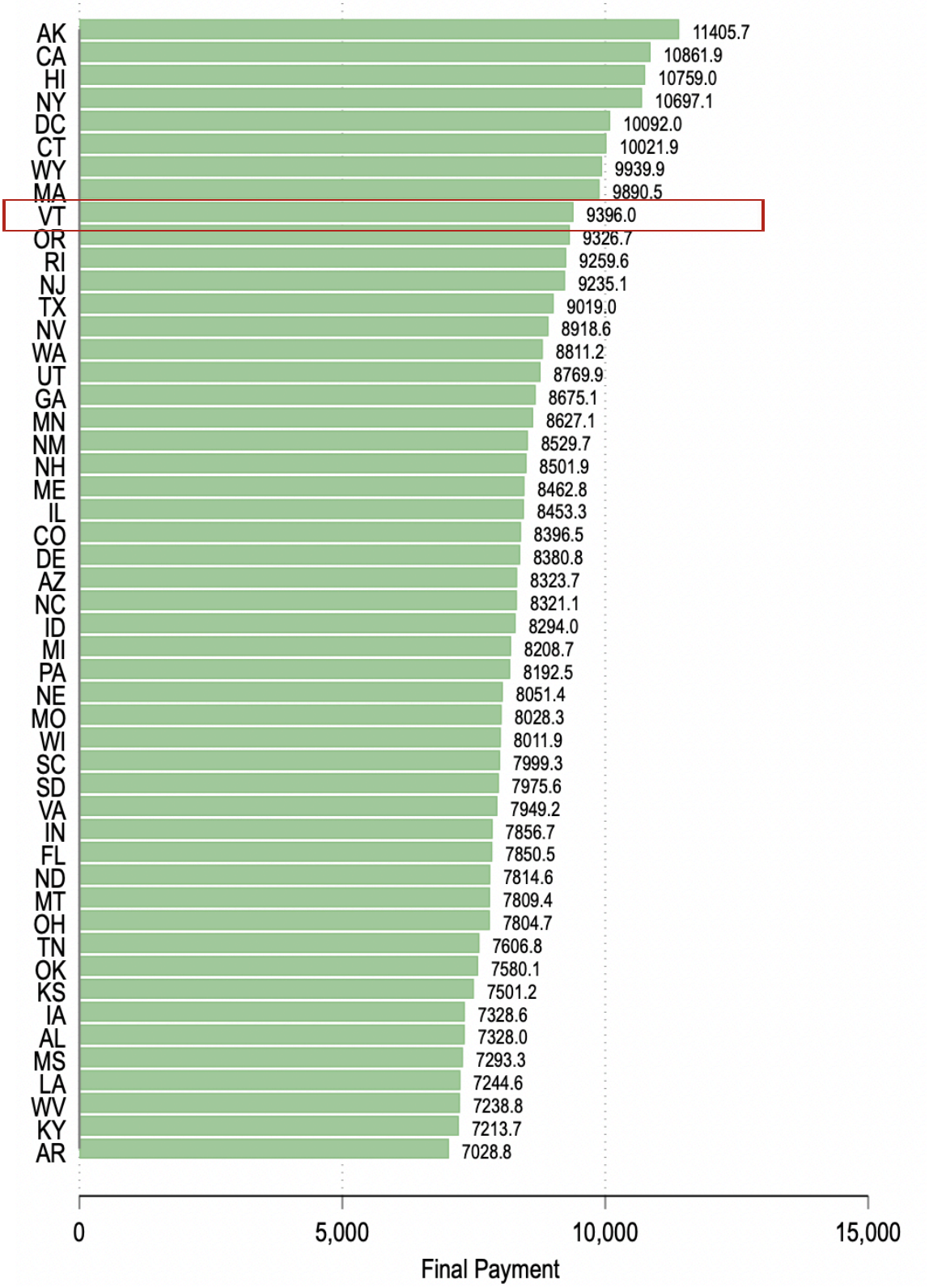


Figure 5. Share of base rate and add-on payments to Medicare final IPPS payment.

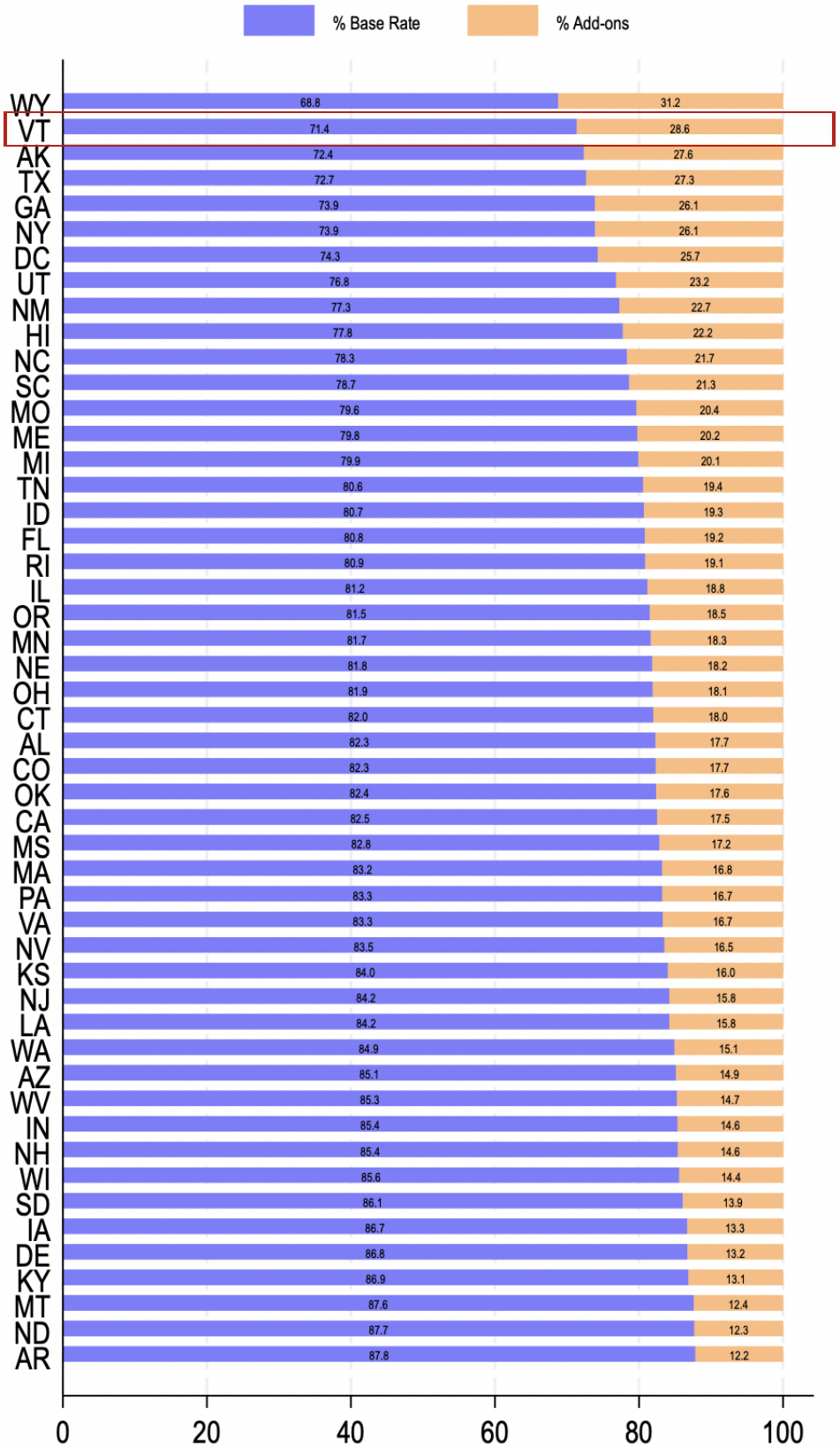


Figure 6. Sum of average Medicare base rate and add-on payments by state.

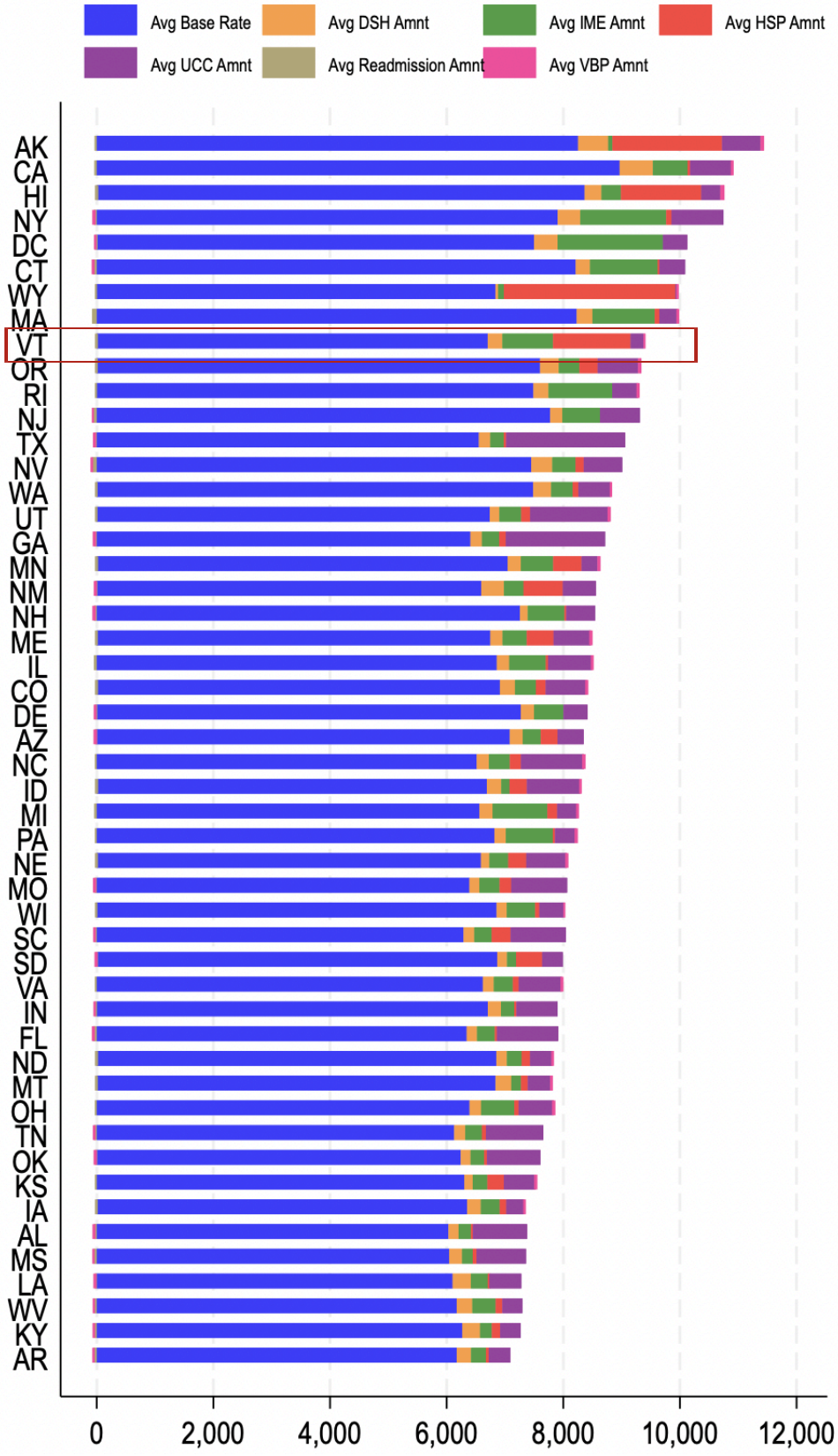


Figure 7. Sum of Medicare base rate for a standardized case and add-on payments by PPS hospital (indicated by each hospital's Medicare provider number) in Maine, New Hampshire, and Vermont.

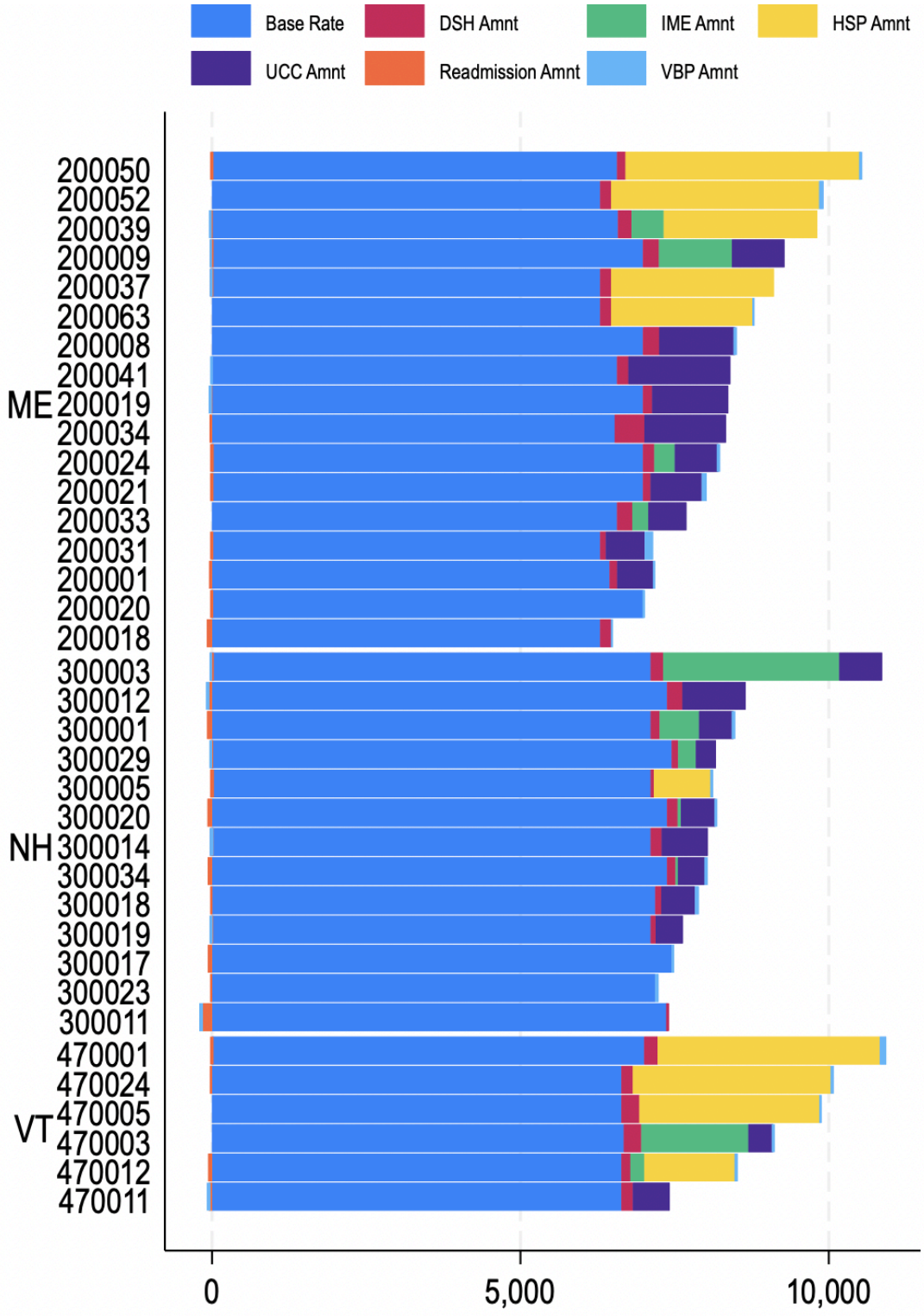


Figure 8. Comparing average Medicare final IPPS payments for a standardized case at the University of Vermont Medical Center to peer academic medical centers (indicated by each hospital's Medicare provider number).

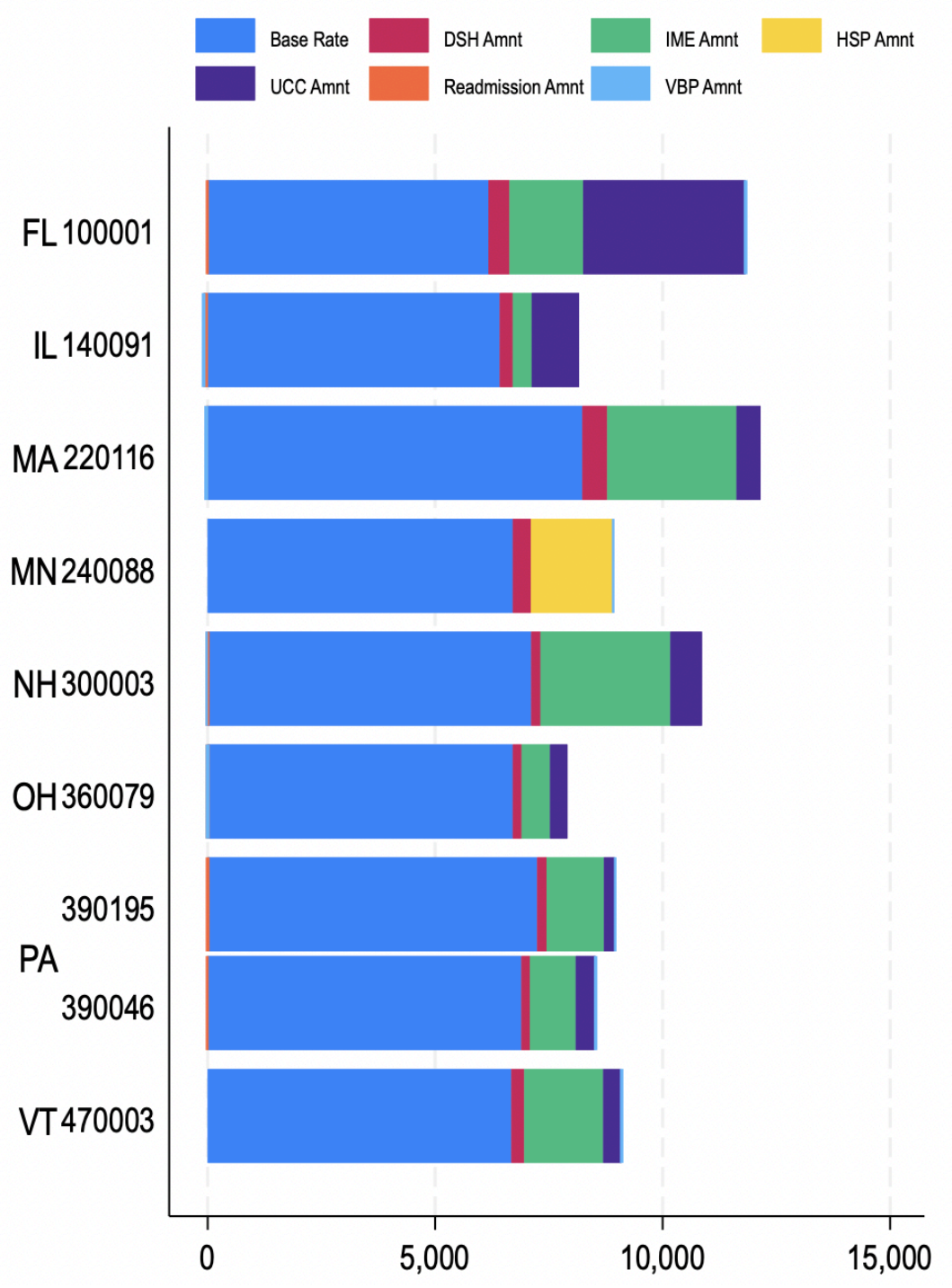


Figure 9. Comparing average Medicare final IPPS payments for a standardized case at other Vermont PPS hospitals to other mid-sized community hospitals (indicated by each hospital's Medicare provider number).

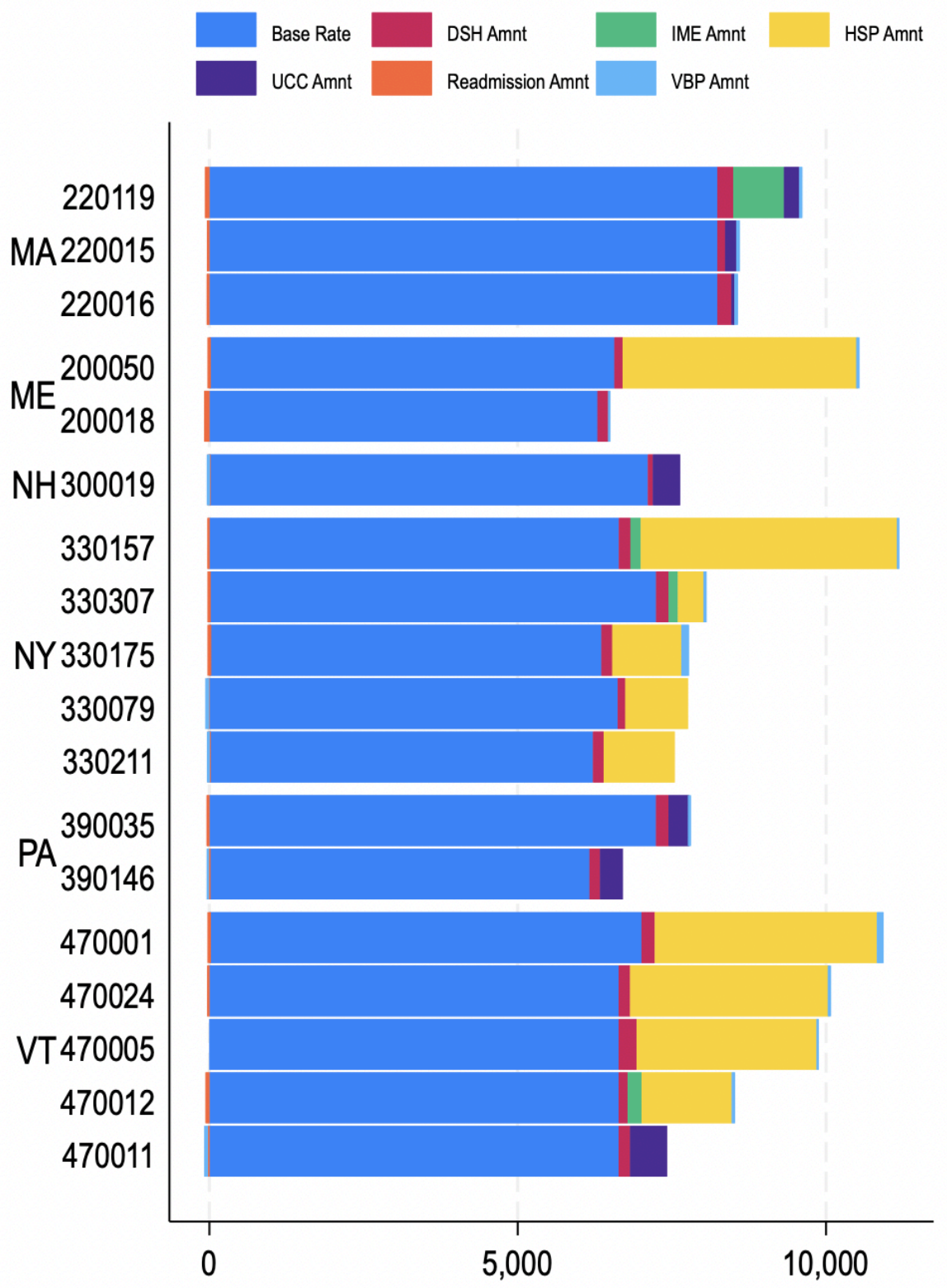
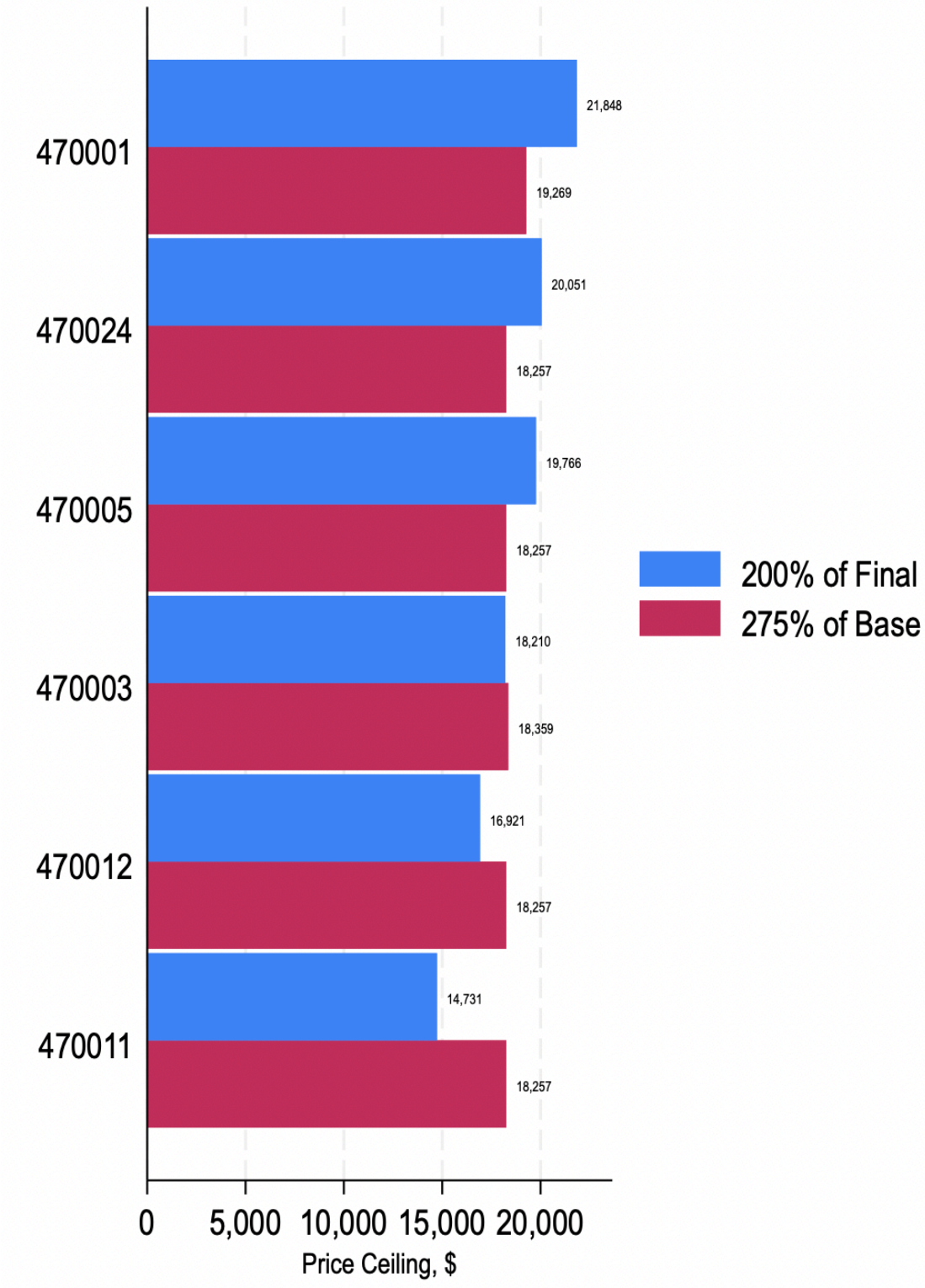
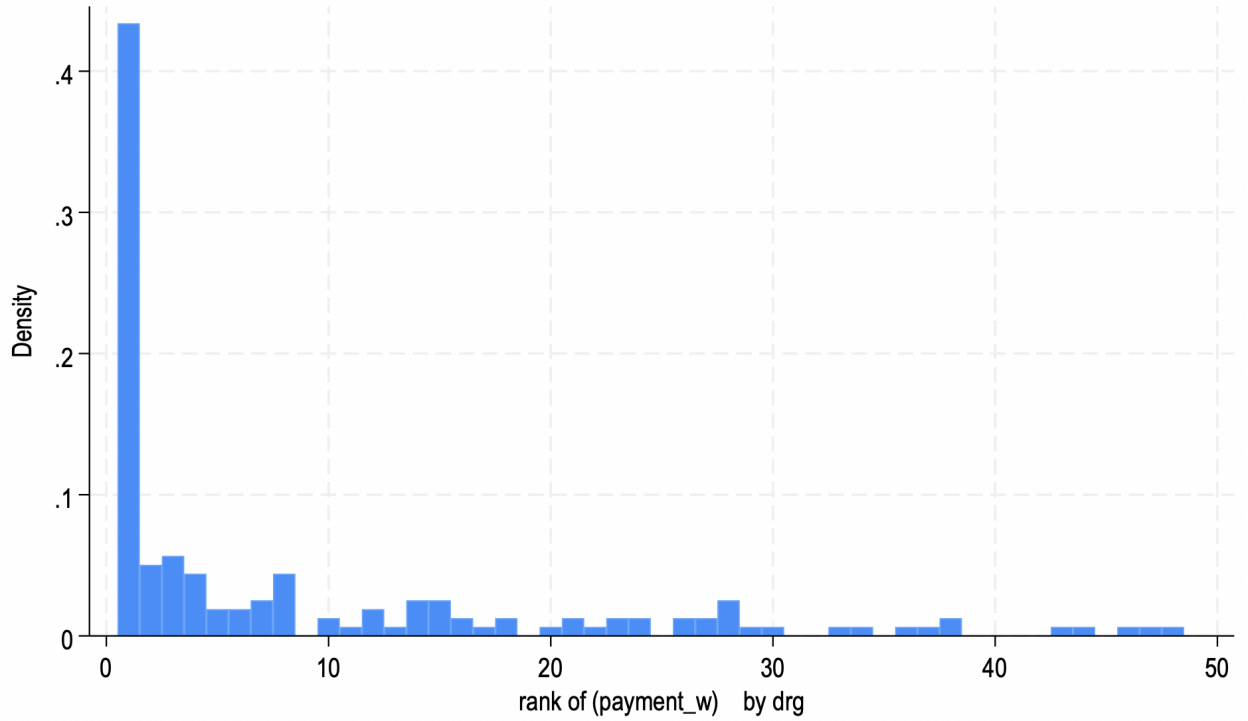


Figure 10. Average commercial price ceiling set at 200% of average Medicare final IPPS payment or 275% of the base rate for a standardized case, 2023.



VII. Appendix: Analysis Using CMS Public Use Files, 2023

Appendix Figure 1. Histogram of Vermont Medicare payment rank by MS-DRG using CMS Public Use Files, 2023.



Notes: *Vermont Medicare payment rank and average payment for 159 MS-DRGs using CMS Public Use Files (2023). The lowest average payment for an MS-DRG is a rank of 1, and the highest average payment for an MS-DRG is a rank of 51.*

Appendix Table 1. State-level inter-hospital transfer rates using Medicare claims, 2023.

State	Inter-hospital transfer rate
VT	4.6%
WY	3.9%
ME	3.8%
SD	3.5%
NH	3.1%
NE	3.0%
IA	2.9%
WV	2.8%
MD	2.6%
CA	2.6%
OH	2.5%
WI	2.5%
NJ	2.5%
MA	2.4%
KY	2.4%
AK	2.4%
SC	2.4%
NM	2.4%
WA	2.3%
MT	2.2%
KS	2.2%
PA	2.2%
MN	2.2%
AR	2.2%
OK	2.1%
VA	2.1%
OR	2.1%
IL	2.1%
IN	2.1%
NC	2.0%
RI	2.0%
NY	2.0%
AZ	2.0%
GA	2.0%
ND	1.9%
CT	1.8%
TN	1.8%
MS	1.8%
MO	1.8%
MI	1.8%
AL	1.7%
UT	1.7%
ID	1.6%
DE	1.6%
TX	1.6%
CO	1.5%
FL	1.5%
LA	1.4%
DC	1.2%
HI	1.2%
NV	1.1%