Agency of Human Services Office of Health Care Reform

Health Care System Transformation Report

REPORT DATE:	SENT TO:	SENT FROM:	HOURS SPENT PREPARING THIS REPORT:
10/1/2025	Health Reform Oversight Committee, Joint Fiscal Committee	Sarah Rosenblum, Interim Director of Health Care Reform	6 Hours

KEY TAKEAWAYS

- **Report Overview**: Act 68 charged the Agency of Human Services (AHS) with identifying and tracking outcome measures to assess progress toward health care transformation goals outlined in Act 167 of 2022.
- **New and Updated Measures:**
  - The report highlights the anticipated impact of the Green Mountain Care Board's (GMCB) recent hospital budget review on key System Transformation Outcome Measures, including:
    - Vermont's Prospective Payment System (PPS) hospitals are expected to become less profitable per adjusted discharge compared to other non-profit PPS hospitals nationally. Administrative and management labor costs per adjusted discharge are anticipated to decline.
    - The life-weighted medical loss ratio for Blue Cross Blue Shield of Vermont (BCBSVT) is expected to stabilize, with opportunities to increase reserves and improve affordability for households.
  - Data was updated for 30-Day Follow-Up After ED Visit for Mental Illness and 30-Day Follow-Up After ED Visit for Alcohol Use, with performance rates of 76% and 68%, respectively.
- **Care Transformation Planning and Measurement:** AHS continues to advance hospital transformation planning and held five regional planning meetings with hospital leadership in August and September 2025. AHS also launched the Act 68 Hospital Transformation Grant Opportunity to support the development and implementation of hospital and regional transformation plans. AHS is partnering with the GMCB to procure an analytics vendor to strengthen modeling capacity. This will support evaluation of proposed changes in terms of quality, cost, and access, and quantify potential cost savings. Specific clinical and financial outcome metrics will be identified for each strategy to measure progress over time.

HEALTH CARE SYSTEM TRANSFORMATION: SUMMARY OF KEY OUTCOME MEASURES

Measure	Act 167 of 2022 Goals					VT Current Performance	VT Benchmark Performance* (Newly Reported)	Diff. Between Current & Benchmark Performance (Newly Reported)
	Reduce Inefficiencies	Lower Costs	Improve Access	Improve Health Outcomes	Reduce Health Inequities			
30-Day All-Cause Readmission Rate	✓	✓				14.5%	15.5%	-1.0%
Potentially Avoidable Emergency Department (ED) Visits as a Percentage of all ED Visits	✓	✓				32.3%	-	-
Operating Profit per Adjusted Discharge	✓	✓				PPS: $5,345 CAH: $938	PPS: $4,162 CAH: $2,784	PPS: $1,183 CAH: -$1,846
Management and Administrative Cost per Adjusted Discharge	✓	✓				PPS: $2,730 No CAH data	PPS: $1,427 No CAH data	PPS: $1,303 No CAH data
Direct Patient Care Labor Cost per Adjusted Discharge	✓	✓				PPS: $6,183 No CAH data	PPS: $6,270 No CAH data	PPS: -$87 No CAH data
Life-Weighted Federal Medical Loss Ratio for Marketplace Plans	✓	✓				89.2%	-	-
Insurance Rate Affordability for Medium-High Utilization Families of Four on Individual Market		✓				Not affordable	-	-
Percent of Vermonters Who Report Having a Personal Health Care Provider (PCP)			✓	✓		91%	87%	-4%
Percent of Primary Care Practices Accepting New Medicaid Patients			✓			59%	-	-
Vermont Adults Who Have Been Told They Have Hypertension				✓	✓	33%	37%	-3%

Measure	Act 167 of 2022 Goals					VT Current Performance	VT Benchmark Performance* (Newly Reported)	Diff. Between Current & Benchmark Performance (Newly Reported)
	Reduce Inefficiencies	Lower Costs	Improve Access	Improve Health Outcomes	Reduce Health Inequities			
Vermont Adults Who Have Ever Been Diagnosed with Diabetes				✓	✓	9%	13%	-4%
Blueprint Patient-Centered Medical Home (PCMH)-attributed Patients with Hypertension Who Have Blood Pressure Under Control				✓		77%	-	-
Blueprint PCMH-attributed Patients with Diabetes Who Have HbA1c **Not** Under Control				✓		22%	-	-
ED Visits for Suicide Ideation or Self-Harm per 10,000 ED Visits				✓	✓	240.6	-	-
ED Visits for Opioid Overdose per 10,000 ED Visits				✓	✓	20.4	-	-
30-Day Follow-Up After ED Visit for Mental Illness				✓	✓	76%	-	-
30-Day Follow-Up After ED Visit for Alcohol Use				✓	✓	68%	-	-

* Note. Benchmarks are set at the 75th percentile of national peers' performance. "Per adjusted discharge" benchmarks relate to US non-profit hospitals and are weighted by adjusted discharge. "PPS" or "Prospective Payment System" hospitals are larger institutions that provide higher-intensity care. "CAH" or "Critical Access Hospitals" are smaller institutions that provide less-intensive care and rely disproportionately on Medicaid dollars. Please note that CAH values do not include Copley or Porter data, which are not reported in the source data. All other benchmarks relate to performance at the state level, i.e., "the state ranked at the 75th percentile for a given measure's performance."

BACKGROUND

Act 68 of 2025, an act relating to health care payment and delivery system reform, charged the Agency of Human Services (AHS) with identifying "specific outcome measures for determining whether, when, and to what extent" the following goals of its health care system transformation efforts have been met, pursuant to Act 167 of 2022: reduce inefficiencies; lower costs; improve health outcomes; reduce health inequities; and increase access to essential services.

Earlier iterations of this report can be found on the Health Care Reform website. This report and future iterations highlight changes in selected measures and their outcomes as they occur.

HEALTH CARE SYSTEM TRANSFORMATION OUTCOME MEASURES

Summary of Updates Since Last Submission

Few updates are available for this report's measures and their benchmarks since the last submission on September 1, 2025. This section will instead focus on two elements:

1. The outcome of the FY 2026 non-psychiatric hospital budget review, and
2. Said outcome's expected impact on System Transformation Outcome Measures.

The Green Mountain Care Board completed its review of non-psychiatric hospital budgets in mid-September. The outcomes can be summarized as follows:

- **Two percent reduction in Vermont hospitals' average commercial rate** from the past year, heavily weighted by an 8.9% reduction in the commercial rate for University of Vermont Medical Center, Vermont's largest recipient of commercial claims. Note that **no hospitals received an increase** in commercial rates.
- **Two and a half percent reduction in Vermont hospitals' all-payer net patient revenue** due entirely to **mandated reductions in commercial net patient revenue**, most of which are derived from University of Vermont Medical Center.
- **Little change in Vermont hospitals' operating expenses**, resulting in a modest reduction in purchasing power of hospitals after inflation.

AHS does not expect the impact of these regulatory decisions to be reflected in this report's measures for at least two years; it remains to be seen whether hospitals' actual budgets align with what has been approved, and there will be a further lag in reporting the actual outcomes. However, AHS anticipates the following impacts on the hospital- and payer-focused measures featured in this report:

- Vermont's **Prospective Payment System (PPS) hospitals will become less profitable per adjusted discharge** relative to the benchmark of other non-profit PPS hospitals in the United States—an improvement for the purpose of this report. The **administrative and management labor cost per adjusted discharge will also decline**. The impact on direct patient care labor costs at PPS hospitals, as well as the impact on CAHs across all metrics, are currently unclear.
- The **life-weighted medical loss ratio of Blue Cross Blue Shield of Vermont (BCBSVT) will stabilize**, all else held constant, as premium growth is constrained by August rate review

decisions and incurred claim costs at hospitals are constrained by September hospital budget review decisions.

- BCBSVT will have an opportunity to increase its contribution to reserves and restore its risk-based capital—an integral component of insurer solvency—to levels recommended by the Department of Financial Regulation. **BCBSVT will also have an opportunity to make health insurance more affordable for more households.**

Process for Evaluating Outcome Measure Performance

AHS continues to advance hospital transformation planning at the local, regional, and statewide level. In August and September 2025, AHS held the first round of regional planning meetings with hospital leadership from 14 Vermont hospitals across five regions of Vermont. Early discussions focused on improving hospital to hospital transfers, expanding shared services, and changes to clinical services delivery that improve outcomes, lower cost and ensure patients are getting the right care at the right time in the right setting. To support hospitals in the development and implementation of hospital and regional transformation plans and strategies, AHS launched the Hospital Transformation Grant Opportunity on September 22, 2025, utilizing funding appropriated in Act 68 of 2025. Additional detail about AHS's approach to supporting care transformation can be found in the October 1, 2025 Health Care Spending Reduction Report, located on the Health Care Reform website.

To support prioritization and evaluation of proposed transformation strategies, AHS is partnering with GMCB to procure an analytics vendor to strengthen modeling capacity. This will allow the state to evaluate hospital proposals in terms of quality, cost, and access, assess alignment with regional and statewide goals, and quantify potential cost savings using evidence-based methods. As transformation strategies and goals are finalized, AHS will identify specific clinical and financial outcome metrics (i.e., anticipated savings) for each strategy to measure progress over time. Measures will be selected based on alignment with transformation goals and the availability of timely and reliable data.

AHS FUNDING FOR CARE TRANSFORMATION

The table below summarizes State and Federal funds received by AHS to support care transformation efforts as of September 25, 2025:

	State Funds	Federal Funds
Appropriated, not yet obligated	$4.02M	$1.2M *(contingent upon participation with AHEAD)*
Obligated	$2.2M	$0.0
Spent	$602,000	$0.0

State funds spent to date have supported AHS's work with the Rural Health Redesign Center (RHRC). The RHRC contract will conclude in early October. Obligated funds currently reflect the remaining

contract value, including deliverables not yet invoiced and anticipated unspent funds. Obligated funds also include contractor support from Manatt, Phelps, and Phillips LLP to assist with development of the State's application for the federal Rural Health Transformation Program established by H.R.1. Remaining appropriated state funds from Act 68 include $2.02 million from the General Fund and $2 million from the Health Information Technology (HIT) fund. In September, AHS launched the Hospital Transformation Grant Opportunity, which will utilize the $2 million from the HIT fund.

For Federal funds, the Centers for Medicaid and Medicare Services Innovation Center (CMMI) has approved $1.2 million in funds for health system transformation grants, available through Vermont's participation in the AHEAD Model and beginning in Cooperative Agreement Year 3 (2027). Potential changes to the AHEAD Model timeline may lead the Agency to use these funds in later years; final decisions will be made once the updated timeline is confirmed. Should the State choose not to participate in the AHEAD Model, any unspent funds from the Cooperative Agreement would need to be returned to CMMI within 90 days.

CLOSING

AHS continues to advance the critical work of developing, implementing, and evaluating and monitoring a health care transformation strategy that aligns with the goals of Act 167 of 2022. We look forward to continuing to work closely with you and other legislative partners to evaluate and monitor the state of Vermont's health care system and the progress towards these goals in a manner that is both timely and comprehensive.

APPENDIX A: SOURCES OF OUTCOME MEASURES

Measure	Act 167 of 2022 Goals					Latest Data	Source
	Reduce Inefficiencies	Lower Costs	Improve Access	Improve Outcomes	Reduce Inequities		
30-Day All-Cause Readmission	✓	✓				2022-2023	VDH via CMS
Potentially Avoidable ED Visits as a Percentage of all ED Visits	✓	✓				2020-2022	Oliver Wyman via VUHDDS/VHCURES
Operating Profit per Adjusted Discharge	✓	✓				2023	NASHP via CMS
Management and Administrative Labor Cost per Adjusted Discharge	✓	✓				2023	NASHP via CMS
Direct Patient Care Labor Cost per Adjusted Discharge	✓	✓				2023	NASHP via CMS
Life-Weighted Federal Medical Loss Ratio for Marketplace Plans	✓	✓				2026 (as approved)	GMCB Decision
Insurance Rate Affordability for Marketplace Plans		✓				2026 (as approved)	GMCB Decision
Percent of Vermonters Who Report Having a Personal Health Care Provider (PCP)			✓	✓		2023	VDH via BRFSS
Percent of Primary Care Practices Accepting New Medicaid Patients			✓			June 2025	VCCI
Vermont Adults Who Have Been Told They Have Hypertension				✓	✓	2023	VDH via BRFSS
Vermont Adults Who Have Ever Been Diagnosed with Diabetes				✓	✓	2023	VDH via BRFSS
Blueprint PCMH-attributed Patients with Hypertension Who Have Blood Pressure Under Control				✓		2023	Blueprint for Health
Blueprint PCMH-attributed Patients with Diabetes Who Have Hba1c **Not** Under Control				✓		2023	Blueprint for Health

Measure	Act 167 of 2022 Goals					Latest Data	Source
	Reduce Inefficiencies	Lower Costs	Improve Access	Improve Outcomes	Reduce Inequities		
ED Visits for Suicide Ideation or Self-Harm				✓	✓	July 2025	VDH
ED Visits for Opioid Overdose				✓	✓	July 2025	VDH
30-Day Follow-Up After ED Visit for Alcohol Use among PCMH-attributed Patients				✓	✓	2023	Blueprint via VHCURES
30-Day Follow-Up After ED Visit for Alcohol Use among PCMH-attributed Patients				✓	✓	2023	Blueprint via VHCURES

APPENDIX B: WHY EACH MEASURE IS INCLUDED

Domain	Measure	Why This Measure is Included
Providers	30-Day All-Cause Readmission Rate	This metric indicates how often patients return to the hospital within 30 days of discharge, serving as a key indicator of care quality, discharge planning effectiveness, and care continuity across the healthcare system.
	Potentially Avoidable ED Visits as a Percentage of all ED Visits	This metric indicates how effectively the health care system manages routine or non-urgent care outside of emergency settings, highlighting gaps in primary care access or care coordination.
	Operating Profit per Adjusted Discharge	This measure reflects the financial health and sustainability of hospitals by showing how much profit is generated per patient, adjusted for case mix and service intensity.
	Management and Administrative Cost per Adjusted Discharge	This metric helps assess hospital operational efficiency by revealing how much is spent on non-clinical overhead relative to patient volume and complexity.
	Direct Patient Care Labor Cost per Adjusted Discharge	This measure captures staffing intensity and labor investment in patient care, providing insight into resource allocation and potential quality of care.
Payers	Life-Weighted Federal Medical Loss Ratio (MLR) for Marketplace Plans	This metric shows the proportion of premium revenue spent on medical care and quality improvement, weighted by enrollment, offering insight into how effectively insurers are using funds to deliver value to enrollees in the health insurance marketplace.
	Insurance Rate Affordability for Medium-High Utilization Families of Four on Individual Market	GMCB's metric of health insurance affordability establishes that a plan is considered affordable for a given household only if post-subsidy plan premiums, cost sharing, and deductibles fall below an established standard.
Patients	Percent of Vermonters who Report Having a Personal Health Care Provider (PCP)	This measure reflects Vermonters' connection to a health care provider for regular, preventative care visits.
	Percent of Primary Care Practices Accepting New Medicaid Patients	This measure reflects access to care for low-income populations; higher acceptance rates signal better access and equity for Medicaid enrollees, who often face systemic barriers to care.
	Vermont Adults Who Have Been Told They Have Hypertension	High rates of hypertension can indicate unmet needs in preventive and chronic care, especially in underserved populations, contributing to worse long-term health outcomes and health inequities.
	Vermont Adults Who Have Ever Been Diagnosed with Diabetes	This measure signals the burden of chronic disease and reflects both individual and systemic factors, such as access to primary care, and disease management resources.

Domain	Measure	Why This Measure is Included
	Blueprint PCMH-attributed Patients with Hypertension Who Have Blood Pressure Under Control	This measure reflects those who have been diagnosed with hypertension and have blood pressure below 140/90. Those with hypertension can expect better health outcomes if their blood pressure is under control.
	Blueprint PCMH-attributed Patients with Diabetes Who Have HbA1c **Not** Under Control	This measure reflects those with diabetes whose blood sugar levels over a two- to three-month period exceed 9%. Those with diabetes can expect more complications related to their condition if their HbA1c remains not under control.
	ED Visits for Suicide Ideation or Self-Harm per 10,000 ED Visits	Tracking mental health crises through ED utilization helps identify gaps in behavioral health services and points to urgent needs in vulnerable populations disproportionately affected by mental illness.
	ED Visits for Opioid Overdose per 10,000 ED Visits	This measure highlights the impact of the opioid crisis and can uncover geographic or demographic disparities in addiction, access to treatment, and social determinants of health.
	30-Day Follow-Up After ED Visit for Mental Illness	This measure highlights the importance of follow-up to improve outcomes for mental illness, reducing the likelihood that a patient will require emergent care for their condition in the future.
	30-Day Follow-Up After ED Visit for Alcohol Use	This measure highlights the importance of follow-up to improve outcomes for alcohol use, reducing the likelihood that a patient will require emergent care for their condition in the future.

APPENDIX C: HOSPITAL EFFICIENCY AND COST MEASURES

Hospital	30-Day All-Cause Readmission Rate	Potentially Avoidable ED Visits / All ED Visits	Operating Profit per Adj. Discharge	Mgmt. and Admin Labor Cost per Adj. Discharge	Direct Patient Care Labor Cost per Adj. Discharge
University of Vermont Medical Center (PPS)	14.3%	29.9%	$ 11,043	$ 3,826	$ 7,704
Rutland Regional Medical Center (PPS)	14.7%	30.7%	$ 3,734	$ 2,432	$ 6,784
Central Vermont Medical Center (PPS)	15.3%	33.4%	$ (1,492)	$ 1,651	$ 5,116
Southwestern (PPS)	14.2%	30.7%	$ 294	$ 1,676	$ 3,231
Northwestern (PPS)	14.0%	37.9%	$ (496)	$ 1,599	$ 4,829
Brattleboro (PPS)	14.2%	33.7%	$ 208	$ 1,462	$ 3,928
North Country (CAH)	14.4%	39.5%	$ 636	-	-
Northeastern (CAH)	14.4%	34.8%	$ 1,632	-	-
Springfield (CAH)	14.4%	33.2%	$ 461	-	-
Gifford (CAH)	14.7%	33.2%	$ 129	-	-
Mt. Ascutney (CAH)	14.8%	37.7%	$ 4,462	-	-
Grace Cottage (CAH)	15.1%	34.1%	$ (2,747)	-	-
Copley (CAH)	15.2%	35.6%	-	-	-
Porter (CAH)	14.7%	39.1%	-	-	-
VT Average (weighted by adj. discharges)	14.5%	32.3%	$ 5,345 (PPS) $ 938 (CAH)	$ 2,730 (PPS) No CAH data	$ 6,183 (PPS) No CAH data
Benchmark (US 75th Percentile Hospital, weighted by adj. discharges)	15.5%	No data available	$ 4,162 (PPS) $ 2,784 (CAH)	$ 1,427 (PPS) No CAH data	$ 6,270 (PPS) No CAH data
Difference (VT Average - Benchmark, weighted by adj. discharges)	**-1.0%**	**No data available**	**$ 1,183 (PPS)** **-$ 1,846 (CAH)**	**$ 1,303 (PPS)** No CAH data	**-$ 87 (PPS)** No CAH data

Note: Data are derived from Hospital Provider Cost Reports submitted annually by hospitals to the Centers for Medicare & Medicaid Services. Copley and Porter lack adjusted discharge data for the CY 2023 reporting year. Critical access hospitals do not report management and admin or direct patient care labor costs. US averages do not account for differences in the characteristics of US hospitals and Vermont hospitals—including hospital size, payer mix, hospitals' role in the broader health care system, or the propensity to report certain data components to CMS.

APPENDIX D: HEALTH OUTCOMES AND THEIR INEQUITIES

Measure and Population	U.S. Benchmark	Vermont Outcome	Vermont Outcome Inequities
Vermont Adults Who Have Been Told They Have Hypertension	37%	33%	▪ 37% of low-income cohort. ▪ 47% of those with disabilities. ▪ Hypertension rates increase with age.
Vermont Adults Who Have Ever Been Diagnosed with Diabetes	13%	9%	▪ 12% for low-income cohort. ▪ 16% for those with disabilities. ▪ Diabetes rates increase with age.
Blueprint PCMH-attributed Patients with Hypertension Who Have Blood Pressure Under Control	No concurrent data available	77%	▪ Rates are lower around Springfield (67%), Rutland (67%) and Bennington (68%).
Blueprint PCMH-attributed Patients with Diabetes Who Have Hba1c **Not** Under Control	No concurrent data available	22%	▪ Regional breakdowns have not been published.
ED Visits for Suicide Ideation or Self-Harm per 10,000 ED Visits by Vermont residents	No concurrent data available	240.6	▪ Rates are double among those 15-24 years old and higher than average among those 25-44 years old.
ED Visits for Opioid Overdose per 10,000 ED Visits by Vermont residents	No concurrent data available	20.4	▪ Rates are higher in Bennington and Windham counties and among those aged 40-49 years old.
30-Day Follow-Up After ED Visit for Mental Illness among PCMH-attributed Patients	No concurrent data available	81%	▪ Rates are lower in the Addison, Lamoille, Rutland, and Washington counties.
30-Day Follow-Up After ED Visit for Alcohol Use among PCMH-attributed Patients	No concurrent data available	67%	▪ Rates are lower in southern Vermont outside Rutland County and the Northeast Kingdom.