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:
9/1/2025	Health Reform Oversight Committee, Joint Fiscal Committee	Brendan Krause, Director of Health Care Reform	20 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. This report builds on the initial report, submitted August 1, 2025.
- **New & Updated Measures:** Two new measures were added related to emergency department visit follow-up. Where available, data for existing measures was updated. Key updates include:
    - Vermont's larger hospitals tend to be costlier but more profitable than peer hospitals while Critical Access Hospitals are less profitable than peer hospitals;
    - There are persistent affordability challenges in Marketplace Plans despite regulatory reductions to premium rate increases; and,
    - Vermonters have a lower prevalence of some chronic conditions and are more likely to report having a primary care provider.
- **Hospital Transformation Planning**: AHS is launching the first regional planning meeting this month. As hospital and regional transformation strategies and goals are finalized, AHS will identify clinical and financial outcome metrics 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				✓	✓	225.1	-	-
ED Visits for Opioid Overdose per 10,000 ED Visits				✓	✓	14.9	-	-
30-Day Follow-Up After ED Visit for Mental Illness **(Newly Reported)**				✓	✓	76%	-	-
30-Day Follow-Up After ED Visit for Alcohol Use **(Newly Reported)**				✓	✓	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.

The initial iteration of this report, from August 1, 2025, contained information on how outcome measures were selected and on Vermont's current performance on those measures. In an effort not to provide repetitive information each month, this report and future iterations will only highlight changes in selected measures and their outcomes as they occur.

HEALTH CARE SYSTEM TRANSFORMATION OUTCOME MEASURES

Summary of Updates Since Last Submission

Several updates have been made to this report since its last submission.

- National averages have been replaced with performance benchmarks as points of comparison. All performance benchmarks are set at the 75th percentile of national performance for all hospitals ("per adjusted discharge" measures) or all states.
- Updates have been made to the data where available: GMCB Affordability Standard for Marketplace Plans; Life-Weighted Medical Loss Ratio for Marketplace Plans; ED Visits for Suicide Ideation or Self Harm; and ED Visits for Substance Use Disorder.
- Two new measures have been added. These measures were selected due to the importance of post-acute and rehabilitative interventions in improving health outcomes among those with mental health or substance use disorders.

Details on updated measure selection and performance

The measures selected to monitor provider and payer performance have not changed since the last report. However, the addition of performance benchmarks and the conclusion of insurance rate review for Marketplace plans provide additional context on the state of Vermont's health care system. Key updates include:

- Vermont hospitals' aggregate **30-Day All-Cause Readmission rate aligns with the national average**, as noted in the previous report, and thus perform better than the benchmark.
- Vermont's Prospective Payment System (PPS) hospitals tend to be costlier but more profitable than 75% of other non-profit PPS hospitals in the United States when weighted by adjusted discharge:
    - **$1,183 more operating profit per adjusted discharge** than the benchmark;
    - **$1,303 more administrative and management labor cost** per adjusted discharge; and
    - **$87 less direct care labor cost** per adjusted discharge.

  Meanwhile, Vermont's Critical Access Hospitals (CAHs) report **$1,846 less operating profit per adjusted discharge** than the lower operating profit per adjusted discharge than the benchmark

for non-profit CAHs throughout the United States. CAHs do not report measures related to direct care or administrative/management labor costs.

- The Green Mountain Care Board closed its filings for the 2026 Marketplace plans:
    - The Board's published decisions **do not indicate any change to the number of individual or small group plans that are considered** affordable to different household types—defined by household size, income, and health care spending—even as individual and small-group premiums are set to rise at the lowest rates in five years.
    - The decisions also **do not indicate any change to Marketplace plans' life-weighted medical loss ratios**, or the percentage of premium dollars that go toward health care claims.

The performance of patient-focused measures is in large part unchanged from the previous report. Changes to the measures, their values, and their benchmarks are noted below:

- Vermont adults are more likely to report **having a primary care provider (91%)** than their peers in other states. Vermont is among 10 states with a rate higher than 87%.
- Vermont adults **are less likely to have been diagnosed with hypertension (33%) or diabetes (9%)** than their peers in other states. Vermont is among the ten states with the lowest rates of both age-sensitive conditions despite being home to one of the oldest populations among all states.
- There are **no significant differences in the rate of ED Visits for Suicide Ideation/Self Harm** or ED Visits for **Opioid Overdose** per 10,000 ED Visits in the last month.
- Two measures have been added since the previous report:
    - **Eighty-one percent of ED Visits for Mental Illness among PCMH-attributed Patients had a follow-up visit within 30 days** of their ED visit. Regions with lower follow-up rates include Morrisville (75%), Middlebury (76%), Rutland (77%), and Barre (78%).
    - **Sixty-seven percent of ED Visits for Alcohol Use among PCMH-attributed Patients had a follow-up visit within 30 days** of their ED visit. The Northeast Kingdom and southern Vermont outside Rutland County have rates below 60%.

Process for Evaluating Outcome Measure Performance

AHS and our contractor, the Rural Health Redesign Center, continue to advance hospital transformation planning at the local, regional, and statewide level. AHS is holding the first regional planning meeting for the northeastern region on Thursday, August 28, 2025. Meetings for four other regions – northwestern, central, southeastern, and southwestern Vermont – are being planned for September 2025. In preparation for these discussions, AHS's contractor completed analyses of hospital service lines and community needs, and developed straw proposals for regionalization. Materials have been shared with the hospitals and will serve as a starting point for discussion at the regional meetings. Initial meetings will be hospital-focused, with additional providers and community-based organizations identified over time. Early focus areas of regional discussions include administrative efficiencies and shared services opportunities, regional approaches to recruiting and staffing, and coordination of care and patient transportation to keep patients closer to home while providing high quality services at centers of excellence. For example, hospitals in one region have expressed the need to strengthen

neurology, pulmonology, and urology in their region and are open to regional approaches if that provides the needed coverage and cost efficiencies. Tertiary hospitals have discussed ways in which they may be able to provide specialty coverage to communities with smaller hospitals that have recruiting and retention challenges. These and other examples are at early stages, but hospitals that have met with the AHS team are open to working on solutions.

Draft goals are being refined in partnership with hospitals to select priorities that will guide both individual hospital plans and regional transformation plan development. 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 August 25, 2025:

	State Funds	Federal Funds
Spent	$557,000	$0.0
Obligated	$2.2M	$0.0
Appropriated	$4.02M	$1.2M *(contingent upon participation with AHEAD)*

For State Funds, spent funds represent those used to fund RHRC, AHS's care transformation contractor. Obligated funds represent the full remaining value of RHRC's contract with AHS as well as contractor support to assist with development of the State's application for the federal Rural Health Transformation Fund established by H.R.1. Remaining appropriated funds from Act 68 include $2.02 million from the General Fund and $2 million from the Health Information Technology (HIT) fund.

For Federal Funds, 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 remains committed to 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 working

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	225.1	▪ 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	14.9	▪ 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.