Agency of Human Services Office of Health Care Reform

Health Care System Transformation Report

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7/1/2026	Health Reform Oversight Committee and Joint Fiscal Committee	Eli Hawgood, Health Reform Portfolio Director	3.5

KEY TAKEAWAYS

- **Act 68 of 2025** 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.
- There are no updates to the measures for this month's report.
- **Care Transformation Planning and Measurement**: All 14 Vermont hospitals have submitted goals to work toward transformation objectives, a reflection of the statewide commitment to reshaping health care delivery in ways that are sustainable for communities and patients alike. Transformation is an ongoing process, and goals will continue to evolve as capacity, partnerships, and resources develop. Achieving Vermont's long-term health care goals will require engaging primary care organizations, designated agencies, specialty providers, and other community-based providers in the same work, building a fully integrated system that delivers on the promise of better care, lower costs, and greater equity for all Vermonters. AHS is now focused on providing resources to ensure these initiatives move forward and accelerate the pace for change where possible.

HEALTH CARE SYSTEM TRANSFORMATION: SUMMARY OF KEY OUTCOME MEASURES

Measure	Act 167 of 2022 Goals					VT Current Performance	VT Benchmark Performance*	Diff. Between Current & Benchmark Performance
	Reduce Inefficiencies	Lower Costs	Improve Access	Improve Health Outcomes	Reduce Health Inequities			
30-Day All-Cause Readmission Rate	✓	✓				14.8%	15.0%	0.2%
Potentially Avoidable Emergency Department (ED) Visits as a Percentage of all ED Visits	✓	✓				32.3%	-	-
Operating Profit per Adjusted Discharge	✓	✓				PPS: $4,767 CAH: $1,464	PPS: $4,805 CAH: $2,817	PPS: -$38 CAH: -$1,353
Management and Administrative Cost per Adjusted Discharge	✓	✓				PPS: $2,988 No CAH data	PPS: $1,549 No CAH data	PPS: $1,439 No CAH data
Direct Patient Care Labor Cost per Adjusted Discharge	✓	✓				PPS: $5,416 No CAH data	PPS: $6,071 No CAH data	PPS: -$655 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)			✓	✓		90%	87%	-3%
Percent of Primary Care Practices Accepting New Medicaid Patients			✓			71%	-	-

Measure	Act 167 of 2022 Goals					VT Current Performance	VT Benchmark Performance*	Diff. Between Current & Benchmark Performance
	Reduce Inefficiencies	Lower Costs	Improve Access	Improve Health Outcomes	Reduce Health Inequities			
Vermont Adults Who Have Been Told They Have Hypertension				✓	✓	33%	37%	-3%
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				✓	✓	230.9	-	-
*ED Visits for Opioid Overdose per 10,000 ED Visits **(removed)***				✓	✓	-	-	-
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

There are no measure updates to this month's report.

Activities to Impact Outcome Measure Performance

The Act 68 grant opportunity, which is supported by a $2 million Health-IT Fund allocation to AHS for fiscal year 2026, is designed to support hospitals actively participating in health care transformation efforts. On September 22, the Agency launched this grant opportunity to provide funding for the development and implementation of hospital and regional transformation plans. Details on the opportunity can be found here. All eligible hospitals are participating, indicating strong engagement with AHS in developing their transformation plans.

At the hospital level, each of Vermont's 14 hospitals has developed an individual transformation plan outlining the specific initiatives that they are ready to implement in support of statewide and regional goals. Many cited opportunities to realize efficiencies through shared technology, opportunities to move care out of hospitals via telehealth, and service line innovation considerations. Rural Health Transformation funding opportunities align well with these initiatives and are being targeted to accelerate this work.

Advanced analytics and technical assistance vendors have initiated work to bring more data driven insights to this transformation effort. Advanced analytics will create scenario models that can inform where we want our health system to go. Technical assistance will ensure hospitals and other providers have the resources they need to implement the initiatives.

AHS FUNDING FOR CARE TRANSFORMATION

The table below summarizes State funds received by AHS to support care transformation efforts as of June 20, 2026:

Appropriation	Statutory Language	Status	(Anticipated) Use of Funds
2025 Budget Adjustment Act (BAA)			
$2.75M of Global Commitment Investment Funding	N/A	Spent ($1.1M) or Obligated	A portion of these funds was spent to support work with the Rural Health Redesign Center (RHRC). The RHRC contract concluded on October 9th and all funds owed to RHRC have been spent. The remaining funds are obligated to support a new contract with a care transformation hospital technical assistance vendor.
Act 68 of 2025			
$2M of General Fund	"feasibility analysis and transformation plan development with hospitals, designated agencies, primary care organizations, and other community-based providers"	Spent ($218K) or Obligated	• A portion of these funds was spent on a Health Care Workforce Leadership Summit and is spent or obligated for contracted transformation support from Manatt, Phelps and Phillips LLP and Dr. Craig Jones. • Remaining obligated funds will allow for contractor provision of analytics to support the development of regional plans that will inform the Health Care Delivery Strategic Plan. This contract is currently under negotiation.
$100K of General Fund	"for development of quality and access measures, targets, and monitoring strategies for the Statewide Health Care Delivery Strategic Plan"	Appropriated	Development of evaluation and monitoring strategy for the Health Care Delivery Strategic Plan.
$100K of General Fund	"to support the development of alternative payment models"	Appropriated	Support implementation of Medicaid hospital global budgets.
$2M of Health IT-Fund	"for grants to hospitals for the collaborative efforts to reduce hospital costs in accordance with Secs. 11a and 11c of this act and to expand access to health care services, such as by enhancing telehealth infrastructure development"	Obligated or Appropriated	Hospital transformation grants; all 13 eligible hospitals have fully executed grant agreements with obligated funds.

Appropriation	Statutory Language	Status	(Anticipated) Use of Funds
$6.95M Total			

For Federal funds, the State has anticipated funding through two sources: the AHEAD Model and the Rural Healthcare Transformation (RHT) Program.

- **AHEAD Model**: 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.
- **RHT Program**: The Centers for Medicaid and Medicare Services awarded the State of Vermont $195,053,740 in Federal Fiscal Year 2026 (FFY26) as part of the five-year RHT Program. Two RHT projects are directly related to care transformation:
    1) funding for additional transformation data analytics and modeling ($15M in FFY26);
    2) funding for transformation, innovation, and regionalization support grants for Vermont providers ($27M in FFY26).

CLOSING

AHS continues to advance the critical work of developing, implementing, 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 Rate	✓	✓				2023-2024	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	✓	✓				2024	NASHP via CMS
Management and Administrative Labor Cost per Adjusted Discharge	✓	✓				2024	NASHP via CMS
Direct Patient Care Labor Cost per Adjusted Discharge	✓	✓				2024	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)			✓	✓		2024	VDH via BRFSS
Percent of Primary Care Practices Accepting New Medicaid Patients			✓			May 2025	VCCI
Vermont Adults Who Have Been Told They Have Hypertension				✓	✓	2023	VDH via BRFSS
Vermont Adults Who Have Ever Been Diagnosed with Diabetes				✓	✓	2024	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				✓	✓	April 2026	VDH
ED Visits for Opioid Overdose (removed)				✓	✓	*March 2026*	*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 (Removed)	*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)	14.7%	29.9%	$7,381	$ 4,797	$ 6,826
Rutland Regional Medical Center (PPS)	14.7%	30.7%	$ 3,143	$ 1,587	$ 4,455
Central Vermont Medical Center (PPS)	15.3%	33.4%	$ 7,199	$ 1,510	$ 5,255
Southwestern (PPS)	15.8%	30.7%	$ 750	$ 1,509	$ 3,058
Northwestern (PPS)	14.0%	37.9%	$ 417	$ 1,625	$ 4,278
Brattleboro (PPS)	14.4%	33.7%	$ (471)	$ 1,625	$ 4,621
North Country (CAH)	14.6%	39.5%	$ 1,150	-	-
Northeastern (CAH)	15.4%	34.8%	$ 2,232	-	-
Springfield (CAH)	15.1%	33.2%	$ 952	-	-
Gifford (CAH)	14.7%	33.2%	$ 1,100	-	-
Mt. Ascutney (CAH)	14.7%	37.7%	$ 4,485	-	-
Grace Cottage (CAH)	14.8%	34.1%	$ (6,707)	-	-
Copley (CAH)	14.9%	35.6%	-	-	-
Porter (CAH)	14.7%	39.1%	-	-	-
VT Average (weighted by adj. discharge)	14.8%	32.3%	$ 4,767 (PPS) $ 1,464 (CAH)	$ 2,988 (PPS) No CAH data	$ 5,416 (PPS) No CAH data
Benchmark (US 75th Percentile Hospital, weighted by adj. discharges)	15.0%	No data available	$ 4,805 (PPS) $ 2,817 (CAH)	$ 1,549 (PPS) No CAH data	$ 6,071 (PPS) No CAH data
Difference (VT Average - Benchmark, weighted by adj. discharge	-0.2%	**No data available**	**$ -38 (PPS)** **-$ 1,353 (CAH)**	**$ 1,439 (PPS)** No CAH data	**-$ 655 (PPS)** No CAH data

Note: Data are derived from Hospital Provider Cost Reports submitted annually by hospitals to the Centers for Medicare & Medicaid Services, which are then processed by the National Academy for State Health Policy (NASHP). Copley and Porter lack adjusted discharge data for the 2024 hospital fiscal year (October 2023 through September 2024). 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	230.9	▪ Rates are higher in Rutland and Windham counties and among those aged 15- 44 years old.
ED Visits for Opioid Overdose per 10,000 ED Visits by Vermont residents (removed)	*No concurrent data available*	*14.5*	▪ *Rates are higher in Chittenden, Caledonia, Bennington and Windham counties and among those aged 30-49 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.