# 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: |
|---|---|---|---|
| 9/1/2026 | Health Reform Oversight Committee and Joint Fiscal Committee | Eli Hawgood, Health Reform Portfolio Director | 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.
- Several measures have been updated:
  - There were 228.6 ER visits for suicide ideation or self-harm per 10,000 ER visits in July– in line with the three-year average.
  - Seventy-five percent of Blueprint PCMH-attributed primary care practices were accepting new Medicaid patients in Q2 CY 2026, up slightly from Q2 CY 2025.
  - Seventy-seven percent of ED visits for mental health had a follow-up visit within 30 days in 2024, consistent with the previous year.
  - Sixty-eight percent of ED visits for alcohol use had a follow-up visit within 30 days, consistent with the previous year.
  - Twenty-two percent of Blueprint PCMH-attributed patients with diabetes did not have HbA1c under control, consistent with the previous year.
  - Sixty-two percent of Blueprint PCMH-attributed patients with hypertension had blood pressure under control, an improvement over the previous year.
- **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 have continued to evolve.

# 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<br>CAH: $1,464 | PPS: $4,805<br>CAH: $2,817 | PPS: -$38<br>CAH: -$1,353 |
| Management and Administrative Cost per Adjusted Discharge | ✓ | ✓ | | | | PPS: $2,988<br>No CAH data | PPS: $1,549<br>No CAH data | PPS: $1,439<br>No CAH data |
| Direct Patient Care Labor Cost per Adjusted Discharge | ✓ | ✓ | | | | PPS: $5,416<br>No CAH data | PPS: $6,071<br>No CAH data | PPS: -$655<br>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 **(updated)** | | ✓ | | | | 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 **(updated)** | | | ✓ | | | 75% | - | - |

| 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 **(updated)** | | | | ✓ | | 62% | - | - |
| Blueprint PCMH-attributed Patients with Diabetes Who Have HbA1c **Not** Under Control **(updated)** | | | | ✓ | | 22% | - | - |
| ED Visits for Suicide Ideation or Self-Harm per 10,000 ED Visits **(updated)** | | | | ✓ | ✓ | 228.6 | - | - |
| ED Visits for Opioid Overdose per 10,000 ED Visits | | | | ✓ | ✓ | 16.7 | - | - |
| 30-Day Follow-Up After ED Visit for Mental Illness **(updated)** | | | | ✓ | ✓ | 77% | - | - |
| 30-Day Follow-Up After ED Visit for Alcohol Use **(updated)** | | | | ✓ | ✓ | 68% | - | - |

* Note. Benchmarks are set at the 75$^{th}$ 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 75$^{th}$ 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

Several updates have been made to the values of the standard measures:

- There were 228.6 ER visits for suicide ideation or self-harm per 10,000 ER visits in July– in line with the three-year average.
- Seventy-five percent of Blueprint PCMH-attributed primary care practices were accepting new Medicaid patients in Q2 CY 2026, up slightly from Q2 CY 2025.
- Seventy-seven percent of ED visits for mental health had a follow-up visit within 30 days in 2024, consistent with the previous year.
- Sixty-eight percent of ED visits for alcohol use had a follow-up visit within 30 days, consistent with the previous year.
- Twenty-two percent of Blueprint PCMH-attributed patients with diabetes did not have HbA1c under control—consistent with the previous year.
- Sixty-two percent of Blueprint PCMH-attributed patients with hypertension had blood pressure under control—an improvement over the previous year.

### 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, 2025, 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 August 24, 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 9,2025, 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.<br>• 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. |

| Appropriation | Statutory Language | Status | (Anticipated) Use of Funds |
|---|---|---|---|
| $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" | Spent ($327,061.58) or Obligated | Hospital transformation grants; all 13 eligible hospitals have fully executed grant agreements with obligated funds. AHS has paid out $327,061.58 in grant funds. |
| ***$6.95M Total*** | | | |

For Federal funds, the State has anticipated funding:

- **AHEAD-** On July 23, 2026, the State of Vermont formally notified Centers for Medicare & Medicaid Services (CMS) of its decision to withdraw from the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model. Vermont originally pursued the model when it was launched in 2023 as an opportunity to strengthen our health care systems. However, new policy and operational guidance to bring Vermont in alignment with other AHEAD states substantially reduced anticipated funding to reinvest in some providers like primary care practices.
- **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 will continue regular check-ins with legislative partners to ensure this report evolves to meet both the intent of Act 68 and the state's broader health care reform goals.

# 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 | ✓ | ✓ | | | | CY 2026 plans (as approved) | GMCB Decision |
| Insurance Rate Affordability for Marketplace Plans | | ✓ | | | | CY 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 | | | ✓ | | | Q2 2026 | 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 | | | | ✓ | | 2024 | Blueprint for Health |

| Measure | Act 167 of 2022 Goals | | | | | Latest Data | Source |
|---|---|---|---|---|---|---|---|
| | Reduce Inefficiencies | Lower Costs | Improve Access | Improve Outcomes | Reduce Inequities | | |
| Blueprint PCMH-attributed Patients with Diabetes Who Have Hba1c **Not** Under Control | | | | ✓ | | 2024 | Blueprint for Health |
| ED Visits for Suicide Ideation or Self-Harm | | | | ✓ | ✓ | July 2026 | VDH |
| ED Visits for Opioid Overdose | | | | ✓ | ✓ | June 2026 | VDH |
| 30-Day Follow-Up After ED Visit for Alcohol Use among PCMH-attributed Patients | | | | ✓ | ✓ | 2024 | Blueprint via VHCURES |
| 30-Day Follow-Up After ED Visit for Alcohol Use among PCMH-attributed Patients | | | | ✓ | ✓ | 2024 | 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) | 14.7% | 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)<br>$ 1,464 (CAH) | $ 2,988 (PPS)<br>No CAH data | $ 5,416 (PPS)<br>No CAH data |
| Benchmark (US 75th Percentile Hospital, weighted by adj. discharges) | 15.0% | No data available | $ 4,805 (PPS)<br>$ 2,817 (CAH) | $ 1,549 (PPS)<br>No CAH data | $ 6,071 (PPS)<br>No CAH data |
| **Difference** (VT Average - Benchmark, weighted by adj. discharge | -0.2% | **No data available** | **$ -38 (PPS)**<br>**-$ 1,353 (CAH)** | **$ 1,439 (PPS)**<br>No CAH data | **-$ 655 (PPS)**<br>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.<br>▪ 47% of those with disabilities.<br>▪ Hypertension rates increase with age. |
| Vermont Adults Who Have Ever Been Diagnosed with Diabetes | 13% | 9% | ▪ 12% for low-income cohort.<br>▪ 16% for those with disabilities.<br>▪ Diabetes rates increase with age. |
| Blueprint PCMH-attributed Patients with Hypertension Who Have Blood Pressure Under Control **(updated)** | No concurrent data available | 62% | ▪ Rates are lower near Springfield, Rutland, and Bennington. |
| Blueprint PCMH-attributed Patients with Diabetes Who Have Hba1c **Not** Under Control **(updated)** | 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 **(updated)** | No concurrent data available | 228.6 | ▪ Rates are higher among those aged 15- 44 years old. |
| ED Visits for Opioid Overdose per 10,000 ED Visits by Vermont residents | No concurrent data available | 16.7 | ▪ 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 **(updated)** | No concurrent data available | 77% | ▪ 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 **(updated)** | No concurrent data available | 68% | ▪ Rates are lower in southern Vermont outside Rutland County and the Northeast Kingdom. |