Green Mountain Care Board

2025 Annual Report

Submitted To:
House Committee on Health Care; Senate Committee on Health and Welfare

Published:
January 22, 2026, in accordance with 18 V.S.A. § 9375(d)

VERMONT

Contact Information

From:

Kristen LaJeunesse, Communication & Information Officer
Green Mountain Care Board
Kristen.LaJeunesse@vermont.gov 802-622-4134

Please contact Kristen to request this information in an alternative format or for other accessibility requests.

Table of Contents

Report Summary ____ 4
Executive Summary ____ 5
Health Insurance Regulation ____ 7
Hospital Budget Review ____ 11
Regulating Cost Shifting to Commercial Payers ____ 14
Certificate of Need (CON) ____ 18
Prescription Drug Affordability ____ 20
ACO Oversight: Budget Review and Certification ____ 23
Data & Analytics ____ 25
Health Resource Allocation Plan (HRAP) ____ 28
Health Information Technology ____ 30
Hospital Reference-Based Pricing ____ 31
Health Systems Transformation ____ 35
Federal Partnerships for Health Care Reform ____ 38
Appendices ____ 41
- Appendix A: GMCB Legislative Reports ____ 41
- Appendix B: Green Mountain Care Board Meetings in 2025 ____ 43
- Appendix B: Organizational Chart ____ 47
- Appendix C: GMCB Budget ____ 48
- Appendix D: Board Member Biographies ____ 50
- Appendix E: Glossary ____ 53

Report Summary

By: Green Mountain Care Board (GMCB)

Date: January 22, 2026

Prepared for: House Committee on Health Care; Senate Committee on Health and Welfare

Frequency: Annual Report

Statute: 18 V.S.A. § 9375(d)

Background:

- GMCB is required to annually submit a report on or before January 15 to the House Committee on Health Care and the Senate Committee on Health and Welfare.
- The Annual Report must include updates on each area of GMCB's regulatory work, a report on the impact of the cost shift and uncompensated care, recommendations for modifications to Vermont statutes, and summaries of key findings from GMCB reports such as the Vermont Health Care Expenditure Analysis.
- The Annual Report is a resource to inform legislators and the public about the state of Vermont's health care system and provides an overview of GMCB's work and regulatory decisions from the prior year, during a period of heightened affordability pressure and significant sustainability challenges.

Executive Summary

Vermont's health care system continued to experience significant strain and sustainability risks in 2025. Blue Cross Blue Shield of Vermont (BCBS) faced acute solvency risks, many hospitals had declining margins and low reserves, and health insurance premiums remained some of the highest in the country. Despite this difficult environment, the Green Mountain Care Board (GMCB) was able to deliver much needed relief to Vermonters and our small businesses by greatly reducing insurance premium requests. In fact, Vermont had some of the lowest affordable care act (ACA) rate increases in 2025. This extraordinary outcome was achieved by the legislature and Governor signing Act 55 capping pharmaceutical prices charged by Vermont hospitals and GMCB's hospital enforcement and regulatory efforts.

While GMCB made important progress in 2025 on the health care affordability crisis, the underlying structure of how Vermont delivers care remains problematic and will make it nearly impossible to make meaningful, durable improvement on improving affordability for Vermonters. GMCB, the legislature, and the Governor have long recognized that Vermont's system requires significant restructuring and in 2025 the Agency of Human Services (AHS) was underway in its transformation efforts set in motion by Act 167 (2022) and Act 68 (2025). The federal government recently awarded AHS $195 million per year for 5 years for rural healthcare transformation. These resources present an opportunity to execute and deliver on system-wide transformation needed to create an affordable and sustainable system.

Vermont's reform efforts must focus on shifting certain care out of expensive hospital settings and to more appropriate, and affordable care sites. This will improve access to care, create a more sustainable system, and provide relief to Vermonters and businesses that can no longer afford the nearly annual double-digit increases in health insurance costs. GMCB recognizes that affordability is not only a financial issue but also a barrier to equitable access and improved health outcomes.

In 2025, the Vermont Legislature enacted measures to address health care affordability, reinforcing GMCB's role in cost containment and transparency while expanding its regulatory authority.

Key 2025 legislative changes include:

- **Act 68 (S.126)**: Introduced a framework for hospital reference-based pricing (RBP), directing GMCB to begin implementing RBP by FY2027. This legislation

empowers GMCB to set pricing caps, allocated funding, and authorized two new staff positions dedicated to affordability initiatives.

- **Act 55 (H.266)**: Targeted prescription drug costs by capping outpatient and office-administered drug charges at 120% of the Average Sales Price (ASP). Hospitals are now required to report 340B acquisition and payment data and disclose how 340B revenues are used for community benefit programs.
- **Act 62 (S.63)**: Clarified GMCB's regulatory responsibilities, strengthening its oversight and transparency.
- **Act 49 (H.482):** Permits rate adjustments to safeguard insurer solvency. It also establishes hospital observer authority and enhances transparency in reimbursement structures.
- **Act 15 (H.96):** Raised CON thresholds for specific projects, eliminates jurisdictional distinctions between hospitals and other health care facilities, and expands exemptions from CON review, allowing smaller projects to proceed without review while maintaining adequate oversight for significant projects.

Health Insurance Regulation

GMCB is tasked with reviewing major medical health insurance premium rates in the large group, small group, and individual insurance markets. Within 90 days of submission, GMCB must determine whether a proposed rate is affordable, promotes quality care and access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to Vermont law.

Relevant Statute: 8 V.S.A. § 4026; 18 V.S.A. §§ 9375(b)(6), 9371

Progress in 2025

Rate Filings

GMCB approves rates for fully insured major medical health insurance plans, which represent a relatively small portion of the private health insurance market in Vermont. Approximately 120,000 Vermonters are covered through plans not under GMCB regulation.

GMCB reviewed 10 rate filings in 2025[1] for the 2026 plan year (see Figure 2, following page), reflecting approximately $870 million in health insurance premiums for approximately 80,000 Vermonters. The majority of these Vermonters – just under 70,000 (88%) -- are covered by Affordable Care Act (ACA) ACA-compliant plans purchased through the Exchange (Vermont Health Connect).

Across all filings, insurers requested approximately $120 million in premium increases. GMCB reduced this amount by an estimated $75 million, including a reduction of $68.7 million for plans sold on the Exchange. Approved average rate increases for individual plans were 1.3% (reduced from 6.2%) for MVP Health Plan, Inc. (MVP) and 9.6% (reduced from 23.5%) for Blue Cross and Blue Shield of Vermont (BCBSVT). These were some of the lowest approved rates in the country.[2] Approved average rate changes in the small group market were 2.5% (reduced from 7.5%) for MVP and 4.4% (reduced from 13.5%) for BCBSVT.

Rate Drivers: Increasing capital reserves for BCBSVT due to solvency concerns, and the anticipated deterioration of the risk pool due to expiration of the enhanced

[1] *See* GMCB Rate Review website for a summary of filings and approved rates.
[2] *See* Kaiser Family Foundation, State Health Facts, Percent Change in Average Marketplace Premiums by Metal Tier for 2025-2026.

premium tax credits were significant drivers of the increases in this year's rate requests. Act 55, which will reduce the prices of hospital administered outpatient drugs beginning January 1, 2026, allowed GMCB to reduce premiums. GMCB was also able to decrease premiums in line with hospital budget reductions.

Looking Ahead to 2026

Expiration of Enhanced/Expanded Premium Tax Credits

Since 2021, the federal government has provided an "enhanced" form of premium subsidies for people who purchase an individual plan through the Exchange, including individuals and families above 400% of the federal poverty level. These enhanced premium subsidies expired at the end of 2025.[3] As a result, many people will see net premium increases in 2026 that are significantly higher than the gross premium increases approved by GMCB.

Silver Loading

Recent legislative proposals suggest that Congress may act to fund cost sharing reduction (CSR) payments as soon as 2027. If this happens, it may put an end to the practice of "Silver Loading," which has increased the premium tax credits people are eligible to receive in Vermont through a higher calculation of the price for the Silver Benchmark Plan.

[3] At the time this report is being written, Congress is still considering bills on this issue.

Figure 1: Insurance Rate Filings for the 2025 Review Year

Company Name	Filing Name	Proposed Rate Change	Approved Rate Change	Difference	Estimated Premium Reduction*
Blue Cross Blue Shield of VT	Large Group (Q1, first file)	17.3%	13.7%	3.6%	$1,481,000
Blue Cross Blue Shield of VT	Large Group (Q2, second file)	-2.7%	-2.2%	0.5%	$206,000
MVP Health Plan, Inc.	Large Group	5.9%	1.9%	4.0%	$466,000
Blue Cross Blue Shield of VT	Association Health Plan	11.3%	7.9%	3.4%	$0**
MVP Health Plan, Inc.	Individual	6.2%	1.3%	4.9%	$7,789,000
MVP Health Plan, Inc.	Small Group	7.5%	2.5%	5.0%	$8,805,000
Blue Cross Blue Shield of VT	Individual	23.5%	9.6%	13.9%	$36,586,000
Blue Cross Blue Shield of VT	Small Group	13.5%	4.4%	9.1%	$15,491,000
Cigna Health and Life Ins. Co.	Large Group	18.6%	10.7%	7.9%	$2,919,000
MVP Health Plan, Inc.	Association Health Plan	N/A***	N/A	N/A	$1,219,000**

* Estimated Premium Reduction - Insureds may not stay with the same plan or insurer from year to year. Large Group filings are based on the manual rate and may not be reflective of the actual rate increase. Groups with better experience will see lower rates, and groups with worse experience will see higher rates.

**Estimated premium reduction ignored for BCBS AHP filing due to the group's anticipated switch to MVP's AHP product. The reduction is the difference in the current (BCBS) rates to the new (MVP) rates.

*** New Product

Hospital Budget Review

Annually by October 1, GMCB has the responsibility to review and establish community hospital budgets. In its review, GMCB considers local health care needs and resources, utilization and quality data, hospital administrative costs, and other data, as well as presentations from hospitals and comments from members of the public.

Relevant Statute: 18 V.S.A. §§ 9375(b)(7), 9456, 9371

Reflecting on 2025

Hospital spending accounted for over 41% of total Personal Health Expenditures in Vermont in 2022.[4] As hospitals represent the largest single source of health care spending in the state, and because there has been significant growth in hospital spending since the pandemic, they remain a major driver of total health care spending growth in Vermont.

The hospital budget review process has been in place in Vermont since 1983 and administered by GMCB since 2012. Through its regulation, GMCB aims to strike a careful balance between controlling growth in hospital spending, ensuring access to high-quality, affordable healthcare for Vermonters, maintaining financial sustainability of hospitals, and responding to the evolving healthcare landscape.

GMCB hospital budget review is performed consistent with the State's principles of healthcare reform, including ensuring access and that "overall health care costs must be contained, and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care."

GMCB budget review relies on clearly established benchmarks and compares performance of Vermont hospitals against peer hospitals. GMCB also reviews and considers inflationary metrics, hospital financial health, and the ability of Vermonters to pay large hospital budget increases. In 2025, GMCB also enforced budget orders established for FY2024, where some hospitals exceeded approved budgets.

[4] GMCB Expenditure Analysis 2021 & 2022

FY2024 Enforcement

Two hospitals were notified of their deviations from approved budgets and were asked to explain the factors underlying these overages. Central Vermont Medical Center (CVMC) exceeded its FY24 budget by $23,703,973 and Springfield Hospital by $1,632,594.

After reviewing evidence, conducting hearings, taking extensive public comment, and deliberating on these FY24 overages, GMCB determined that corrective measures to remediate the deviations at CVMC were appropriate. GMCB voted to partially enforce CVMC's overage—$11.7M of the $23.7M total—by reducing future commercial rates by 11.2%.[5]

FY2026 Hospital Budget Review Process

In FY26's hospital budget guidance, GMCB established a Net Patient Revenue (NPR) benchmark of 3.5%, based on targets originating in the state's All Payer Model agreement which aims to bring health care spending in line with economic growth. Budget guidance also benchmarked commercial negotiated rate increases at 3% based on inflation estimates over the prior year. An operating expense growth benchmark of 3% over the prior year's budget was also established to more directly target expense management.[6]

There were several statutory changes that impacted the FY26 budget review process. The Board was directed to evaluate hospitals' financial contributions to networks and executive compensation plans for consistency with state goals, and to compare executive salaries to lowest-paid clinical employees at hospitals. Financially, the most impactful statutory change was the outpatient drug price cap established in Act 55 which was estimated to result in over $100 million in reduced commercial revenue across the system.

Vermont's 14 community hospitals filed their proposed budgets for FY2026 on July 1, 2025, with a fiscal year start of October 1, 2025.

FY2026 Hospital Budget Decisions

Hospitals submitted an aggregate commercial rate increase of 2.6% system-wide over the prior year; GMCB ultimately approved a -2.0% reduction.[7] The FY2026 hospital

[5] CVMC FY24 Order Correcting Budget Deviation and Denying Budget Adjustment Request
[6] FY26 Hospital Budget Guidance
[7] FY26 Submitted vs. Approved Hospital Budgets

budget orders resulted in a systemwide NPR of $3.74 billion, a 0.2% increase over FY2025 approved budgets.

In addition, GMCB adjusted six hospital budget requests in order to limit the rate increase to commercially insured patients. No hospital received a rate increase higher than the benchmark established in Guidance. In reaching its decisions, GMCB considered the sustainability challenges hospitals were facing, as well as issues with access to care. Striking the balance between health care affordability and hospital solvency is increasingly difficult as commercially insured Vermonters disproportionally shoulder the financial burden, despite already unaffordable plans.

Continuous Improvement

GMCB is always looking for ways to improve its efficiency and value for Vermonters. In the hospital budget process, GMCB continues to focus on streamlining its requests to hospitals, focusing on measures that matter and minimizing administrative burdens, and strengthening its reliance on data and evidence to inform its decision-making.

Looking Ahead to 2026

While GMCB does not approve the FY2027 hospital budget guidance until March 2026, staff are already building on progress made in prior years. This includes continued administrative simplification and automation. Given continued healthcare affordability challenges, in addition to a target for commercial net patient revenue, staff will again propose the inclusion of targets for commercial price and operating expense growth.

Regulating Cost Shifting to Commercial Payers

Vermont law requires GMCB to both control cost growth and assess cost shifts to commercial payers. The "cost shift" is the theory that public payer reimbursements to healthcare providers are insufficient to cover providers' costs and, to stay financially viable, providers must charge higher prices to private payers; in other words, private payers subsidize the cost of caring for patients who are insured by public payers. However, the "cost shift" theory has been increasingly challenged by leading academics who posit that some systems may have higher relative negotiating leverage due to greater market power and may be able to demand higher prices beyond what the market would otherwise determine to be an efficient price.[8]

Further, even if the price can be determined to be "efficient" relative to the market for similar services, the "cost shift" assumes that a *hospital's operating costs* are fixed, necessary, and appropriate. However, hospitals experience significant variation in their productivity and efficiency due to a range of internal and external factors.[9] As Vermonters have experienced extreme increases in their health insurance costs, performance benchmarking and operating cost assessments have become increasingly important and an additional mechanism in GMCB's hospital budget review process.

Additionally, how services are configured across hospitals and communities has implications for *system-wide operating costs* (e.g., how much duplication is there in services/infrastructure across communities). While hospitals consider a variety of factors in deciding which services to provide, the services provided may not result in the most efficient on a system level. GMCB's Act 167 community engagement and related work explores opportunities to better balance system-wide efficiencies and community needs.

While GMCB is again submitting this year's cost shift report consistent with existing statue, it recognizes the malleability of hospital and health system costs, considering both costs at the system- as well as hospital-levels, and continues to use its regulatory levers to facilitate improvement.

[8] Hospital Consolidation Continues to Boost Costs, Narrow Access, and Impact Care Quality

[9] Productivity Variation and Input Misallocation: Evidence from Hospitals

Highlights from this year's "cost shift" analysis, and related discussions

Annual Estimated "Cost Shift" Impact

Given extant hospital and health system costs, Figures 1-3 in the below analysis represent the estimated cost shift by payer and by year from FY2010 actuals to FY2026 budget, as historically measured by GMCB. The cost shift is an estimate based on data submitted in the hospital budget process and assumes that each payer should contribute equally to these budgets, accounting for their proportional share of expenses and margins. Though substantively this only represents a "price shift" since costs are not measured directly.

"Cost Shift" Rate of Growth

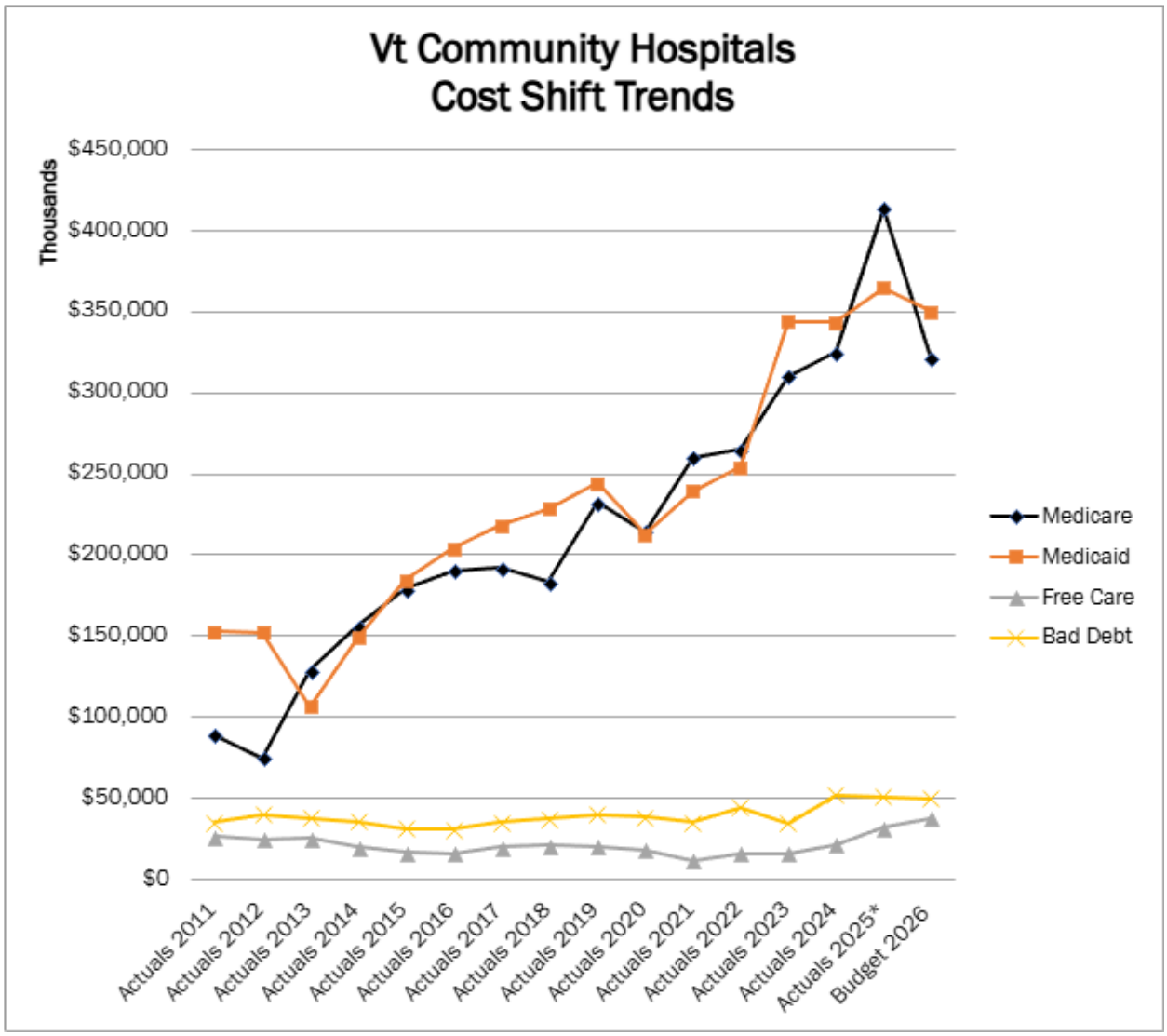
From FY2010 to FY2019, the cost shift appears to have grown at a compound rate of 7.9%, with an estimated growth of -9.8% from FY2019 Actual to FY2020 Actual and 7.8% from FY2020 Actual to FY2026 Budget.

Figure 2: Estimated Cost Shift by Payer (FY2010-FY2025), Vermont Community Hospitals

Fiscal Year	Estimated Medicare Cost of Services Shifted to Other Payers	Estimated Medicaid Cost of Services Shifted to Other Payers	Estimated Free Care Shifted to Other Payers	Estimated Bad Debt Shifted to Other Payers	Estimated Costs Shifted to Commercial and Other Payers	Annual Change	Estimated % Change from Prior Year in Shift to Commercial and Other Payers
Actuals 2010	$ - 73,515,988	$ - 138,016,619	$ - 24,806,398	$ - 33,076,863	$ 269,415,868	$ 19,125,573	7.6%
Actuals 2011	$ - 88,399,861	$ - 152,256,740	$ - 25,784,124	$ - 34,331,093	$ 300,771,818	$ 31,355,950	11.6%
Actuals 2012	$ - 74,383,192	$ - 151,931,648	$ - 24,347,367	$ - 39,264,676	$ 289,926,884	$ - 10,844,935	-3.6%
Actuals 2013	$ - 128,108,641	$ - 105,982,171	$ - 24,684,304	$ - 37,383,822	$ 296,158,938	$ 6,232,054	2.1%
Actuals 2014	$ - 155,622,607	$ - 148,344,481	$ - 19,370,131	$ - 34,885,055	$ 358,222,274	$ 62,063,336	21.0%
Actuals 2015	$ - 178,243,251	$ - 184,115,357	$ - 16,032,485	$ - 30,469,896	$ 408,860,990	$ 50,638,716	14.1%
Actuals 2016	$ - 190,018,540	$ - 203,622,426	$ - 15,683,900	$ - 30,318,995	$ 439,643,861	$ 30,782,871	7.5%
Actuals 2017	$ - 191,515,256	$ - 217,814,796	$ - 19,337,891	$ - 34,451,540	$ 463,119,483	$ 23,475,623	5.3%
Actuals 2018	$ - 182,780,851	$ - 228,177,679	$ - 20,380,418	$ - 36,600,429	$ 467,939,377	$ 4,819,894	1.0%
Actuals 2019	$ - 231,725,743	$ - 243,616,824	$ - 19,635,798	$ - 39,595,820	$ 534,573,257	$ 66,633,880	14.2%
Actuals 2020	$ - 213,990,446	$ - 212,239,269	$ - 17,947,862	$ - 37,824,364	$ 482,001,013	$ - 52,572,244	-9.8%
Actuals 2021	$ - 259,644,195	$ - 239,187,977	$ - 11,311,885	$ - 34,678,866	$ 544,822,923	$ 62,821,910	13.0%
Actuals 2022	$ - 264,629,430	$ - 253,380,720	$ - 15,224,557	$ - 43,723,386	$ 576,958,093	$ 32,135,170	5.9%
Actuals 2023	$ - 309,589,315	$ - 343,281,252	$ - 15,678,943	$ - 34,221,345	$ 702,770,855	$ 125,812,762	21.8%
Actuals 2024	$ - 324,433,810	$ - 342,861,636	$ - 20,889,873	$ - 51,698,178	$ 739,883,496	$ 37,112,642	5.3%
Actuals 2025[10]	$ - 413,305,501	$ - 364,011,814	$ - 31,062,406	$ - 50,594,045	$ 858,973,765	$ 119,090,269	16.1%
Budget 2026	$ - 320,729,768	$ - 349,283,947	$ - 37,469,635	$ - 49,016,386	$ 756,499,736	$ - 102,474,030	-11.9%

[10] FY25 figures reflect unaudited actuals; audited actuals will be available by February 2026

Figure 3: Trends - Estimated Cost of Services Shifted to Other Payers (FY2010-FY2026)



Impact of Medicaid and Medicare Cost Shifts and Uncompensated Care on Health Insurance Premium

In accordance with 18 V.S.A. § 9375(d)(1)(F), GMCB calculated the impact of the "cost shift" on premiums for the products regulated by GMCB, namely, comprehensive major medical health insurance plans in the large group and individual and small group markets.

Findings: With respect to the filings GMCB reviewed in 2025, the costs projected to be shifted to commercial and other payers by facilities and providers impacted by GMCB's hospital budget review contributed to premiums on average 16.3% across all filings; 16.6% for individual and small group filings; and 14.2% for large group filings.

Analysis: GMCB determined what percentage of hospitals' budgeted commercial revenues are due to the cost shift. This is represented by column (C) in the equation below. Next, GMCB determined what percentage of projected premiums are due to projected FY26 hospital spending. This is represented by column (D) in the equation below. GMCB then multiplied column (C) by column (D) to determine that the average impact of the cost shift across all filings was 16.3%, as shown in Figure 3.

Figure 4: Estimated Impact of Vermont Hospital Budgets on Insurance Premiums Observed through Rate Review

Budget 2026	Estimated Costs Shifted to Commercial and Other Payers (A)	GMCB Regulated Hospitals' Budget for Commercial Payers (B)	Percentage Impact on Hospital Budgets for Commercial Payers (C)=(A)/(B)	FY26 Estimated GMCB Hospitals as Percentage of Premium (D)	Impact of Cost Shift on Rate Filings (E)=(C)*(D)
Totals	$756,499,736	$1,935,435,868	39.1%	41.6%	16.3%

GMCB also calculated the average impact of the cost shift by market (i.e., individual, and small group filings and large group filings). Column (D) varies by filing and, on average, is larger for the individual and small group filings (42.4%) than for large group filings (36.2%), resulting in a larger impact on the individual and small group filings (16.6%) compared to large group filings (14.2%).[11]

[11] Individual and Small Group (39.1% * 42.4% = 16.6%). Large Group (39.1% * 36.2% = 14.2%).

Certificate of Need (CON)

Vermont law requires health care facilities to obtain a Certificate of Need before developing a new health care project as defined in 18 V.S.A. § 9434. This includes capital expenditures and new service offerings that meet statutory cost thresholds, purchases or leases of new equipment or technology that meet statutory cost thresholds, changes in the number of licensed beds, offering any new home health services, and health care facility ownership transfers (excluding hospitals and nursing homes). Each project must meet statutory criteria related to access, quality, cost, need, and appropriate allocation of resources. The CON process is intended to prevent unnecessary duplication of health care facilities and services, promote cost containment, and help ensure equitable allocation of resources to all Vermonters.

Act 15 (2025) raised the monetary thresholds that trigger CON review. The capital cost threshold was increased to $10 million; the equipment cost threshold was increased to $5 million; the annual operating expense threshold was increased to $3 million; and the threshold for large projects required to have a conceptual development phase was increased to $50 million. Act 15 also equalized the monetary thresholds for hospitals and non-hospitals and expanded exemptions and exclusions.

Relevant Statute/Authority: 18 V.S.A.§§ 9375(b)(8), 9434.

Progress in 2025

Issued CONs

GMCB approved five CON applications with a total value of $37,508,061.

- University of Vermont Medical Center Radiology Suite 24 Equipment Replacement ($2,906,252)
- Rutland Regional Medical Center Linear Accelerator Replacement ($4,023,049.18)
- Southwestern Vermont Medical Center Creation of an Inpatient Mental Health Unit for Adolescents ($9,500,000)
- Southwestern Vermont Medical Center Cancer Center ($21,000,000)
- 300 Pearl Street Opco LLC, Change in the Number of Licensed Beds ($78,760)

Six projects not reviewable

GMCB determined that six proposed projects did not meet jurisdictional thresholds for CON review.

Applications under review

- The Center for Living & Rehabilitation, Change in the Number of Licensed Beds
- Upper Valley Surgery Center, LLC, Ambulatory Surgical Center

Prescription Drug Affordability

The Green Mountain Care Board is authorized by Act 134 to explore and create a framework and methodology for implementing programs to regulate prescription drug costs in Vermont. We provide resources for the public to better understand our progress, provide available data reports, and share information about various processes underway to improve prescription drug affordability for Vermonters and the Vermont health care system.

Progress in 2025

Prescription Drug Cost Analysis – State Spending
Vermont law 18 V.S.A. § 4635 requires that the Department of Vermont Health Access (DVHA) collect data on prescription drugs that have significantly increased in price, either in their wholesale acquisition cost (WAC) or in their net price to the state. The law requires that DVHA report the data to GMCB on or before June 1 of each year, to better inform the GMCB's regulatory work and to alert the public of drug price increases.

- In adherence to the statute, DVHA gave GMCB two sets of analysis to disclose to the public:
    - *DVHA Analysis on WAC Increases:* This list contains ten drugs that experienced the highest increase in WAC over CY2024 (and that met other criteria specified by the statute). The increases in WAC ranged from 15% for Yupelri (a bronchodilator solution) to 131% for Hydromorphone (an opioid medication).
    - *DVHA Analysis on Net Price Increases:* This list contains ten drugs that experienced the highest increase in net cost to the State over CY2024 (and that met other criteria specified by the statute). The net cost was calculated as the paid amounts for each drug minus all applicable rebate amounts. The average percent increases over one year in net price ranged from 29% for Mydayis to 4594% for Daytrana (both are stimulant medications used in the treatment of ADHD). This year (CY2024), there was a notable shift in net price increases concentrated among branded drugs where, historically, price increases were comprised of mostly generic drugs.

Prescription Drug Cost Analysis – Commercial Spending

Vermont law 18 V.S.A. § 4636 requires that GMCB solicit data from large commercial insurers to publish a report on the effect of pharmaceutical spending on commercial insurance premiums. The statue requires that GMCB solicit the following information from commercial insurers (among other items):

- The 25 most frequently prescribed drugs,
- The 25 most costly drugs,
- The 25 drugs with the highest year-over-year price increases,
- The effects of drug spending on insurance premiums, both as a percentage of premiums and as a dollar figure.

GMCB summarized its findings in the annual Act 193 report. For the 2025 Act 193 reporting cycle, GMCB found that prescription drug spending accounted for approximately $153 to $254 per member per month (PMPM) across reporting insurers, representing roughly 21% to 25% of total monthly premiums. These values continue to reflect an upward trend in both absolute drug spending and the share of premiums attributable to prescription drugs across insurers. Consistent with prior years, specialty drugs represented the largest driver of premium impact for most insurers, accounting for approximately 9% to 14% of premiums, while brand-name drugs accounted for approximately 4% to 9% of premiums.

Generic drugs continued to represent a small share of premiums overall, generally accounting for 1% to 2% of premiums, though notable variation exists across insurers.

Despite generics comprising the majority of prescriptions filled, spending remains concentrated among a relatively small number of high-cost brand and specialty drugs, underscoring their disproportionate influence on premium growth.

For more detailed information on prescription drug monitoring, please refer to the links on the GMCB webpage titled "Prescription Drug Transparency".

Other Regulatory Levers Implemented in 2025 and Looking Ahead to 2026

Act 55 of 2025

18 V.S.A. § 9406 (Act 55 of 2025) requires each Vermont hospital participating in the 340B drug pricing program to report on their participation to GMCB annually by January 31.

This is a new annual report that will be released for the first time in 2026. Vermont hospital 340B program participation reporting is one lever through which the state promotes transparency around hospital drug purchasing and revenue use, supporting ongoing efforts to improve health system performance, affordability, and access to care.

In addition, Act 55 restricts Vermont hospitals (except those designated as independent Critical Access Hospitals) from billing insurers more than 120% of a drug's Average Sales Price (ASP) for provider-administered drugs in outpatient settings. This reform complements insurer reporting mandated by Act 193, extending cost oversight to physician-administered drugs and supporting broader GMCB efforts to promote fair, transparent pricing across care settings. GMCB will continue to track drug costs through the hospital budget review and health insurance rate review processes and work with hospitals and insurers to measure the impact of drugs on insurance rates.

Act 134 of 2024

Vermont has implemented numerous policies over many years seeking to constrain prescription drug spending. However, prescription drug spending continues to be a growing source of financial strain requiring further research and targeted policy recommendations. Act 134 of 2024 authorized GMCB to explore new cost-containment opportunities to ensure that Vermonters have greater access to low-cost prescription drugs. A final report was published in January 2026 examining a view of how small states are working to contain prescription drug costs for consumers, health plans, and providers. The report presents findings and evidence-based recommendations for Vermont policymakers as they assess options that are both appropriate and meaningful initiatives in Vermont, including strategies to lower generic drug costs, the cost of brand drugs and additional opportunities for consideration in reducing costs and improving care.

ACO Oversight: Budget Review and Certification

In 2016, GMCB was given the authority to develop rules and standards to regulate Accountable Care Organizations (ACOs) through Vermont's Act 113: *'An act relating to implementing an all-payer model and oversight of accountable care organizations.'*

GMCB has adopted Rule 5.000 Oversight of Accountable Care Organizations, which establishes standards and processes GMCB will use to certify ACOs and annually review, modify, and approve their budgets, and mechanisms by which GMCB will monitor and oversee the activities performance of ACOs.

Relevant Statute/Authority: 18 V.S.A., §§ 9375(b)(13), 9382

Progress in 2025

2025 Monitoring – OneCare Vermont (OCV)

OneCare Vermont (OCV) announced on November 7, 2024, that FY25 would be its final year in operation. GMCB voted on December 18, 2024, to modify OCV's budget to cut its operating expenses by 11.4% (approximately $1,458,000) and to redirect those funds to independent primary care providers, FQHCs, designated agencies, home health agencies, and area agencies on aging.

The ACO was not required to submit a revised budget in the spring of 2025, however GMCB monitored OCV's compliance with conditions of its FY25 budget order, as outlined in the FY25 Reporting Manual throughout the year.

2025 Monitoring - Medicare-only ACOs

GMCB monitored reporting requirements from all Medicare-only ACOs operating in Vermont. For 2025, there were three of these ACOs in the state: Lore Health ACO LLC (formerly Gather Health), Vytalize Health KS 25 ACO (replacing Vytalize Health 9), and Aledade Accountable Care 205 LLC (a new entrant).

Act 62 - Updated ACO Regulation

In June 2025, Governor Scott signed Act 62 into law, formally modifying how GMCB will regulate ACOs operating in Vermont going forward. ACO budget reviews are now

required only for ACOs contracting with Vermont Medicaid or a Vermont commercial insurer. No ACOs in Vermont will meet these criteria in 2026, therefore no ACO budget reviews occurred in 2025. All ACOs operating in Vermont, regardless of payer, will need to be certified by GMCB by January 1, 2027. After an ACO is certified, it will need to participate in an annual eligibility verification review by GMCB staff to ensure continued compliance with certification requirements. GMCB is updating its Rule 5.000: Oversight of Accountable Care Organizations to align with these new requirements in Act 62 and anticipates final rule adoption in Spring 2026.

Looking Ahead to 2026

Evolving ACO Regulation

For the first time, all ACOs operating in Vermont will be required to be certified by GMCB by January 1, 2027. Staff are involved in rulemaking and designing new processes to align with the new rule. ACOs will apply for certification during the second half of 2026, with GMCB issuing determinations by December 31, 2026. At this time, it is not anticipated that any ACOs will meet requirements for a budget review.

Data & Analytics

GMCB is dedicated to providing timely, consistent, and actionable analyses for the Board's regulatory duties and for the broader public through stewardship of its data resources and standard reporting.

The GMCB Analytics Team produces public reports that provide statistics describing aspects of the Vermont health care system such as analysis of trends in health care costs, quality health care delivery, access to care, and health insurance coverage.

GMCB maintains and manages several data sources, including the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) which is Vermont's all-payer claims database, and the Vermont Uniform Hospital Discharge Data System (VUHDDS) which is Vermont's hospital discharge database. In addition to these rich databases, GMCB collects and uses a vast amount of data through its various regulatory functions.

Progress in 2025

Data Stewardship

GMCB's Data Governance program has matured enough to begin a diligent focus on making data governance operations more efficient. Leaning into the nascent Agile practice, a data governance operations group has initiated a weekly cadence of working sessions, stood up a visual workflow management system, and began industry standard knowledge management practices.

Data Linkage and Integration

The GMCB Data Team successfully stood up an Azure Data Bricks environment, established connections across the first pipelines they have constructed, and moved to a centralized code repository to more tightly manage the build and review process for Data Team-engineered Information Products. This work will automate core operational and reporting workflows, bring GMCB infrastructure up to current day standards, and provide enterprise visibility into Data Team workflows for the first time in the organization's history.

Standard Reporting

Interactive reports available for public use from the GMCB website were updated and expanded. These reports include reports on reimbursement variation, All-Payer Total Cost of Care, patient migration, and commercial insurance market share. Migrating standard reporting into the Microsoft environment began and is on the roadmap to continue into 2026. This work is critical to modernizing and automating GMCB's regularly scheduled workflows within one, vertically integrated data ecosystem, improving efficiency, reducing risk, and improving consistency in product format. This work will begin to free up resources to turn to more value-added work.

Looking Ahead to 2026

VUHDDS Dataset

Management of the hospital discharge dataset (VUHDDS) and associated analytics was moved from the Vermont Department of Health (VDH) to GMCB's Data Team. The Data Team has been enabling the transition by refactoring the entire codebase with view to modernization and efficiency, as well as integrating it into their new Azure DevOps (ADO) environment. ADO will enable full portfolio visibility, centralize code management and repositories to standardize production processes, and fully integrate knowledge management. This work will harden the organization against disruption like turnover, and bring critical organization workflow procedures into a centralized, governed environment for the first time.

A Modern Data Program

Throughout 2026, the Data Team will continue to execute on its three phase Roadmap.

In **Phase 1**, launched in June of 2025, the focus has been on stabilizing operations and embedding Agile practices within the Data Team. This included training in Agile and Scrum methodologies, establishing agile rhythms, and using those practices to manage work intake and retrospectives. A technical debt inventory has begun to be created to identify and prioritize legacy systems and integration issues in highest need of remediation. Simultaneously, a Data Governance Operations (DGOps) function was launched to define roles, workflows, and metadata standards. The team also began onboarding Microsoft tools—SharePoint Online for document management and initial training in Planner, OneDrive, Teams, and Power BI. Key outcomes have included the adoption of Agile work management, deployment of governance artifacts, initiation of the first technical debt inventory, and the initial setup of SharePoint.

Phase 2, scheduled throughout 2026 – 2027 will shift the Data Team's focus toward modernization and consolidation, aiming to streamline operations and automate workflows using the Microsoft stack. Governance tasks will continue to be integrated into agile sprints, and working groups will update standards incrementally. DataOps principles will be introduced through Power Automate and Continuous Integration/Continuous Deployment CI/CD pipeline design. The Microsoft stack will be expanded with Power Platform tools for self-service and workflow automation, and Azure Data Services will be considered for advanced data architecture. Legacy systems will be targeted for retirement, with data migration and decommissioning of redundant tools. By the end of this phase, the team is expected to have embedded Agile governance practices, automated data workflows, and transitioned to modern tools for data collection and reporting.

Phase 3, is focused on optimizing data quality, scaling the modernized platforms, and creating sustainable practices for the long term. It will follow Phase 2, running from 2027-2028, focusing on advanced governance, data stewardship, and quality monitoring, using tools like Copilot and MS Purview for metadata management, data lineage tracking, and cataloging. Efforts will also aim at creating an enterprise data model that standardizes schema, naming conventions, and access protocols, integrating data across various domains into a longitudinal structure.

This part of the roadmap is designed to drive automation and analytics through AI, with MS Copilot helping users interact with data, automate documentation, and generate insights. AI/ML models will be integrated into the data visualization tooling for enhanced analytics.

Regarding culture and sustainability, this part of the roadmap will formalize GMCB's participation in the statewide Data Community of Practice and build a culture of technical learning, documentation, and mentorship for long-term growth. This approach aims to foster sustainable governance and agile maturity, leading to an integrated enterprise data environment. The advanced use of analytics and AI will align GMCB with ADS's standards and enable the organization's data culture to keep tightly knit to GMCB's mission and compliance goals, preparing the organization for a data centric future.

Health Resource Allocation Plan (HRAP)

GMCB maintains and publishes the state's Health Resource Allocation Plan (HRAP), which is intended to capture where health care is needed and where it is being delivered across the state.

HRAP includes dashboards, reports, needs assessments, and inventories that leverage data from GMCB, the Agency of Human Services (AHS), VDH, and other partners. By integrating available data and reports from across state government, HRAP supports GMCB's regulatory work (e.g., the Certificate of Need program) and serves as a resource for health care planning and decision-making across state government, including the AHS-led Statewide Health Care Delivery Strategic Plan. Importantly, HRAP is not a single document or published at a single time; it includes inventories, reports, assessments, etc. that may have been a one-time project or may be a recurring report. GMCB's website has a page where one can go to view the interactive reports and available data.

Relevant Statute: 18 V.S.A. §§ 9375(b)(4), 9405

Progress in 2025

HRAP Process Improvement Road Map

Per 18 V.S.A. § 9403(b)(8)(D), HRAP will be an input to the Statewide Health Care Delivery Strategic Plan. This will require continued development and fine-tuning of priorities for targeted adjustments and new information products. To operationalize these improvements, GMCB created an HRAP Process Improvement Road Map in 2024 and has been mindful of its outline. The road map includes HRAP plans for updating existing visualizations and changes to regulatory processes compared to health care resource and community assessments.

HRAP Framework

GMCB designed an HRAP framework during 2024 to enhance the user experience, which was used throughout 2025. The framework includes four processes: requirement gathering for GMCB regulatory processes, stakeholder engagement, data collection and analysis, and visualization and packaging of information. Utilization, access, and payer mix will be key data indicators for analysis, when applicable.

Stakeholder Engagement

The stakeholder engagement process is ongoing and involves state agencies, legislative representatives as well as regulated entities. Public feedback is solicited through public Board meetings and GMCB's established public comment process.

Looking Ahead to 2026

Data Collection and Management

Since receiving the responsibility for the full data lifecycle of the Vermont Uniform Hospital Discharge Data Set (VUHDDS), GMCB's data program has launched a full-scale modernization effort to bring this critical data asset into alignment with current industry best practices and tooling. Essential data sets that reflect healthcare needs and resources by sector and geographic region will continue to be maintained over the next year. Relevant updates will be highlighted on the GMCB website.

Data Analysis

GMCB aims to include statewide primary care investment and utilization in the next release of the HRAP information product.

Strategic Planning

Ongoing assessments will be conducted to package reports and analyses in a user-friendly way for HRAP audiences.

Data Visualization

In an ongoing effort to streamline data operations, the platforms used for data visualization at GMCB are under review with the intent to lower the overhead for the organization and implement data pipelines. This modernization work will facilitate faster, easier, and lower risk feature development and release for data products going forward.

Health Information Technology

Before 2025, the Green Mountain Care Board (GMCB) had three key roles in health information technology (HIT) and health information exchange (HIE):

- Review and approve the Vermont Health Information Exchange Strategic Plan (HIE Plan)
- Review and approve VHIE Connectivity Criteria
- Review and approve the Vermont Information Technology Leaders (VITL) budget

The Legislature made changes to the GMCB HIE governing statutes to streamline HIE efforts in Vermont. Now, GMCB serves as a voting member on the HIE Steering Committee, reflecting a shift in regulatory focus and redistributing oversight functions.

Relevant Statute/ Authority: Act 62 (2025); 18 V.S.A. § § 9351, 9375(b)(2).

Progress in 2025

Act 62 of 2025 repealed the following GMCB responsibilities:

1. To approve, reject, or request modifications to the HIT Plan submitted by the Department of Vermont Health Access.
2. To review and approve the budgets of VITL.
3. To review criteria for providers to connect to the HIE.

These changes reflect a shift in GMCB's regulatory focus, streamlining its oversight functions, and redistributing responsibilities to other entities broadly.

Looking Ahead to 2026

GMCB's Data Program is focused on modernization and technical debt paydown. This means that the Data Program is pursuing modern data practices, tooling, and processes to begin to support the organization at scale.

Adoption of Agile principles, transition into a single, shared enterprise workflow management environment (Azure DevOps), and a planned entry into the SOV's Data Lake in partnership with Agency of Digital Services, all stand to offer considerable efficiency and technological advancements to GMCB in the coming year.

Hospital Reference-Based Pricing

The core aspects of GMCB's duties are health care affordability and provider sustainability. Given Vermont's position as an outlier on health care spending and hospital prices, the Legislature passed Act 68 of 2025, directing GMCB to utilize its rate setting authority to build a reference-based pricing (RBP) program for all Vermont hospitals. Among other things, Act 68 also permits GMCB to establish price floors for non-hospital providers.

RBP establishes maximum payment amounts for hospital services based on Medicare rates or other benchmarks, adjusted for local factors such as labor costs and community health needs. This approach aims to control commercial insurance costs, rationalize prices, and ensure providers receive fair and adequate compensation. The legislation requires GMCB to begin implementing hospital RBP by fiscal year 2027.

To support this work, the Legislature provided GMCB with two staff positions and $500,000. One position, the Affordability and Pricing Project Director, has been filled, and recruitment is underway for the second position. GMCB has also issued a Request for Proposals (RFP) for analytic work to support the development and implementation of the rate setting program.

Background and Context

- The marketplace average monthly benchmark premium in Vermont is the highest in the nation at $1,299, which is 107% more than the national average of $625.[12]
- As of 2022, Vermont ranked 8th highest in the nation for per-capita personal health care spending at $12,985 (21% higher than the national average of $10,714), largely driven by high hospital spending (35% higher than the national average of $4,043).[13]
- According to the most recent RAND hospital price transparency study, commercial sector prices for total facility payments (inpatient and outpatient, without professional fees) averaged 293% of what Medicare would have paid for the same or similar service in Vermont.[14]
- GMCB's report on RBP for state employees and teachers plans found that Vermont hospital commercial payments averaged 289% of Medicare rates during

[12] https://www.kff.org/affordable-care-act/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Average%20Benchmark%20Premium%22,%22sort%22:%22desc%22%7D
[13] https://altarum.org/sites/default/files/State_Health_Spending_Trends_Blog.pdf
[14] View an interactive dashboard with data from the RAND Hospital Price Transparency Study here: https://dashboard.sagetransparency.org/

2018-2023 and adjusting to 200% of Medicare could have saved approximately $400 million over the study period, with $79 million estimated in 2022 alone; the majority of potential savings would come from outpatient services ($321 million) compared to inpatient services ($78 million).

- Similarly, results from the Brown University Hospital Payment Cap Simulator estimates a cap set at 250% of Medicare for Vermont's state employee health plan would save $41 million and modestly reduce hospital commercial operating margins from 42% to 39%.[15]
- GMCB commissioned economists at Brown University to analyze how Vermont compares to other states on Medicare payment levels when standardized to an average patient. Economists found when payments are standardized to an average Medicare payment, Vermont is among the top 10 states nationally for Medicare payments with disproportionately high payment add-ons compared to other states.[16]
- Implementation of RBP must balance affordability goals with hospital financial sustainability and Vermonters' access to essential services.

Progress in 2025

- GMCB leveraged existing analytic work to accelerate implementation planning for FY2027.
- GMCB released a comprehensive RFP for analytic support to inform a rate setting methodology and program development.
- GMCB hired an Affordability and Pricing Project Director to lead RBP implementation efforts.
- GMCB began developing a regulatory framework and stakeholder engagement process for RBP.

15 https://public.tableau.com/app/profile/jay.shroff6638/viz/PaymentCapAnalysis_17464640301400/Instructions

16 https://gmcboard.vermont.gov/sites/gmcb/files/documents/Analysis%20of%20Medicare%20Final%20Payment%20Rates%20in%20VT_Final_11.18.25_UDA.pdf

Looking ahead to 2026

Hospital Reference-Based Pricing FY2027

GMCB's implementation of reference-based pricing for hospital fiscal year 2027 will be operationalized through the Board's hospital budget guidance issued in March 2026. This guidance will establish the framework for how hospitals should structure their FY2027 budgets in alignment with RBP requirements, including:

- Establish specific rate benchmarks (expressed as a percentage of Medicare for the same or similar services) and adjustment factors for different hospital types (e.g., Critical Access Hospitals, Prospective Payment System Hospitals, and Academic Medical Centers)
- Integrate comparative price analyses into hospital budget deliberations
- Demonstrate readiness to comply with Board-established maximum allowable rates for all inpatient and outpatient medical services

Rulemaking Process

Concurrent with FY2027 budget guidance development, GMCB will engage in formal rulemaking to establish the regulatory framework for hospital reference-based pricing via rate setting beginning in FY2028. This process will include:

- Public stakeholder engagement through advisory committees and public comment periods
- Development of clear standards for rate calculations, adjustments, and approvals
- Establishment of enforcement mechanisms and compliance monitoring procedures

Key Challenges and Considerations

- Balancing cost containment with hospital financial viability, particularly for lower volume hospitals, while managing the potential impact on commercial insurance rates and insurer solvency.
- Ensuring commercial rate adjustments adequately reflect structural differences in hospital costs which may vary based on their geography or role in the system.
- Monitoring quality and access and ensuring alignment with AHS transformation efforts.
- Preventing service reductions that could compromise Vermonters' access to

essential services.

- Coordinating RBP implementation with other payment reform initiatives, including hospital global budgets and the State's potential participation in the AHEAD Model.

Health Systems Transformation

Since 2005, according to the Sheps Center, 195 rural hospitals have closed nationally. At the same time, Vermont faces an affordability crisis. To address the affordability crisis and retain Vermonters' access to high quality essential services requires coordinated and comprehensive health system transformation. While AHS is tasked with leading the planning and implementation of these efforts, GMCB maintains critical data and regulatory responsibilities that must be aligned with State system transformation priorities and goals.

Act 167 of 2022, Act 51 of 2023, and Act 68 of 2025

Act 167 of 2022 charged GMCB, in collaboration with the Director of Health Care Reform in the Agency of Human Services, with facilitating the Community Engagement to Support Hospital Transformation Project, which culminated in the release of the final report in September 2024.

Act 51 of 2023 then transitioned primary responsibility for planning and implementation of health system transformation to AHS.

Act 68 of 2025 built upon this foundation by requiring AHS to establish a comprehensive Statewide Health Care Delivery Strategic Plan by January 2028, to be updated biennially thereafter.

The legislation also reflected recognition of the imminent affordability crisis by requiring AHS to facilitate a 2.5% reduction in hospital spending in FY26. Additionally, the Act acknowledges the financial pressures on the health care system and concerns that hospitals might respond by reducing services that Vermonters need. To address these concerns, the Legislature authorized GMCB to review any hospital proposed service reductions that have not been identified by AHS as part of the health system transformation efforts, and to take appropriate action to preserve Vermonters' access to necessary services.

GMCB-AHS Collaboration

While AHS leads transformation efforts, GMCB maintains critical collaborative responsibilities:

- Aligning the Board's regulatory processes (e.g. hospital budget review, certificate of need, notice of service reduction) with transformation goals and strategic plan priorities.

- Reviewing proposed service reductions through the Notice of Service Reduction process.
- Ensuring payment reform initiatives (including reference-based pricing and potential global budgets) support and reinforce delivery system transformation.
- Providing data analysis and regulatory oversight to support informed decision-making.

Notice of Service Reduction

Prior to the conclusion of the FY2026 hospital budget process, GMCB established its Interim Notice of Service Reduction Policy. This policy establishes a framework for hospitals to notify GMCB when they intend to reduce or eliminate services, ensuring transparency and allowing for State evaluation of community impact. While Act 68 directs the Board to consider hospitals' proposed changes in light of the statewide health care delivery strategic plan, this resource will not be available for reference until January 2028. Thus, the Board's first iteration of this policy reflects an interim policy, and per the statue, leverages hospital community health needs assessments, and the Board's overarching mission to improve affordability, access, and quality as a basis for evaluating proposed service reductions.

Rutland Regional Medical Center Pediatric Care Redesign: Following the conclusion of the hospital budget review process, on October 30th, GMCB received its first Notice of Service Reduction from Rutland Regional Medical Center (RRMC). RRMC notified the State of its intention to redesign its pediatric care delivery model, including closure of its five inpatient pediatric beds. This represented the first application of the new policy. Rutland withdrew its notice prior to a Board vote, opting to incorporate their proposal into transformation work with AHS.

Looking Ahead to 2026

Strategic Planning and Policy Development

- GMCB will fulfill its responsibilities and role supporting the Vermont Sterring Committee for Comprehensive Primary Health Care, the Health Care Delivery Advisory Committee, and the development of the Statewide Health Care Delivery Strategic Plan, which includes establishing a total cost of care target to guide Vermont's efforts toward a more affordable health care system.
- GMCB will continue to learn from the implementation of the Interim Notice of Service Reduction Policy and refine the interim policy as needed over time.

- Both agencies will work to clarify and formalize collaborative workflows at the intersection of payment reform and delivery system transformation.

Enhanced Coordination

- Determining and communicating what service changes are a part of AHS transformation efforts and what service reductions are subject to GMCB review.
- Developing shared data infrastructure and analytic tools to monitor service changes throughout Vermont's health care system.
- Creating mechanisms for hospitals to be transparent and planful about proposed changes while remaining responsive to evolving community needs and financial realities.
- Identifying beneficial transformation initiatives such that they can be considered in the Board’s regulatory processes and decision-making.

Federal Partnerships for Health Care Reform

The end of 2025 marks the end of Vermont's All-Payer ACO Model Agreement with CMS which began in 2017. 2025 also marks the end of operations for Vermont's only statewide all-payer ACO, OneCareVT (OCV).

Evaluations of both the model and the ACO are still on-going, with current evaluations finding mixed to poor results on financial and quality metrics. GMCB is looking ahead to new opportunities for statewide and state-based reform and federal partnerships with CMS/Medicare.

All-Payer ACO Model

The Vermont All-Payer Accountable Care Organization (ACO) Model began January 1, 2017, and concluded December 31, 2025, marking nine performance years (PY0-PY8) of Vermont's groundbreaking partnership with the Center for Medicare and Medicaid Innovation (CMMI). This model represented a collaboration between Vermont and CMMI to test the alignment of payment incentives across all major payers (Medicare, Medicaid, and commercial insurers) throughout Vermont's care delivery system.

OneCare Vermont Wind-Down

OCV, Vermont's primary ACO and a subsidiary of the University of Vermont Health Network (UVMHN), announced in November 2024 that it would wind down operations at the conclusion of 2025, concurrent with the end of the All-Payer Model. Over nearly a decade, OCV developed a variety of capabilities including:

- Population health management programs supporting over 100 participating provider organizations with over 4,000 providers[17].
- Comprehensive Payment Reform (CPR) program for 18 independent primary care practices[18].
- Data analytics and reporting infrastructure providing actionable insights to providers.
- Care coordination and quality improvement initiatives across the continuum.

[17] OneCare Vermont FY25 Budget Guidance Workbook 2.1 and 2.2. Available at: FY25 OCV Budget Guidance Workbook | Green Mountain Care Board.

[18] Comprehensive Payment Reform (CPR) Program Report to Green Mountain Care Board October 2024.

Model Performance and Outcomes

Federal evaluation reports through Performance Year 5 (2022) demonstrated the following results:

- Reduced gross and net Medicare spending compared to states with similar reform activities.
- As of performance year 6 (2023), the compounded annual all-payer growth of 4.8% exceeds the All-Payer ACO Model Agreement target (3.5% - 4.3%). Payer-specific changes ranged from 3.8% (Medicare) and 3.8% (Medicaid) with an observed commercial change of 7.0%.
- Improvements or stability in most population health outcomes and health care delivery quality measures, specifically in improved care coordination and reduced hospital avoidable utilization.[19]

AHEAD Model

In November 2023, CMMI released the Notice of Funding Opportunity (NOFO) for the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. This multi-state initiative features hospital global budgets, enhanced primary care payments, and targets for cost containment, primary care spending, quality, and health equity. AHS submitted Vermont's application in March 2024, and Vermont was formally accepted into AHEAD in July 2024 as a Cohort 2 participant. On January 17, 2025, GMCB voted 3-1 (with one abstention) to join Governor Scott and AHS in signing the AHEAD State Agreement with CMS. This conditional approval includes automatic termination provisions if certain requirements necessary for proper implementation are not met.

With the January 2025 presidential transition came a significant reimagining of the AHEAD model. While many original components remain (e.g. hospital global budgets, enhanced primary care payments), there are numerous new model requirements (e.g. choice and competition legislative policy requirements, geo-AHEAD attribution entities), details on which are sparse and still evolving. As of the end of 2025, one state, Maryland, has signed a new agreement with CMS and has agreed to participate in this new version of AHEAD. Vermont remains in Cohort 2 and expects to continue negotiations into 2026. GMCB has a number of outstanding questions that remain to be

[19] Evaluation of VTAPM 2018-2022 (Vermont All-Payer Accountable Care Organization (ACO) Model)

answered before it can evaluate its subsequent support for this new version of the AHEAD model.

Appendices

Appendix A: GMCB Legislative Reports

GMCB Legislative Reports Submitted in 2025

Report / Requirement	Due Date	Corresponding Statute or Legislation
Preliminary Plan for Prescription Drug Cost Regulation Program	January 15, 2025	2024 Acts and Resolves No. 134, Sec. 1(b)(1)
Impact of Prescription Drug Costs on Health Insurance Premiums (2025)	January 1, 2025 (annually)	18 V.S.A. § 4636
GMCB Annual Report	January 15 (annually)	18 V.S.A. § 9375(d)
Ambulatory Surgery Center Report*[20]	Included in Annual Report	18 V.S.A. § 9375(14)(a)–(b)
Health Care Expenditure Analysis[21]	January 15 (annually)	18 V.S.A. § 9383(c)

[20] The Ambulatory Surgery Center report is in its final stages. The final report will be posted to the GMCB Reports and Resources webpage.

[21] The Health Care Expenditure Analysis Report is in final review and is expected to be released in Spring 2026.

Final Plan for Prescription Drug Cost Regulation Program	January 15, 2026	2024 Acts and Resolves No. 134, Sec. 1(b)(2)
Reporting on Participation in the 340B Drug Pricing Program	January 31 (annually through 2031)	18 V.S.A. § 9406 (H.266 / Act 55)
Hospital Reporting on Security Plan Costs	As required	18 V.S.A. § 9454 (H.259 / Act 9)
Update on RBP, Global Budgeting, Access, Quality, and Cost of Care	February 15, 2026	2025 Acts and Resolves No. 68 (incorporated into Annual Report beginning January 2027)
Annual Bill-Back Report	September 15 (annual)	18 V.S.A. § 9374(h)

Appendix B: Green Mountain Care Board Meetings in 2025

GMCB Board Meetings in 2025

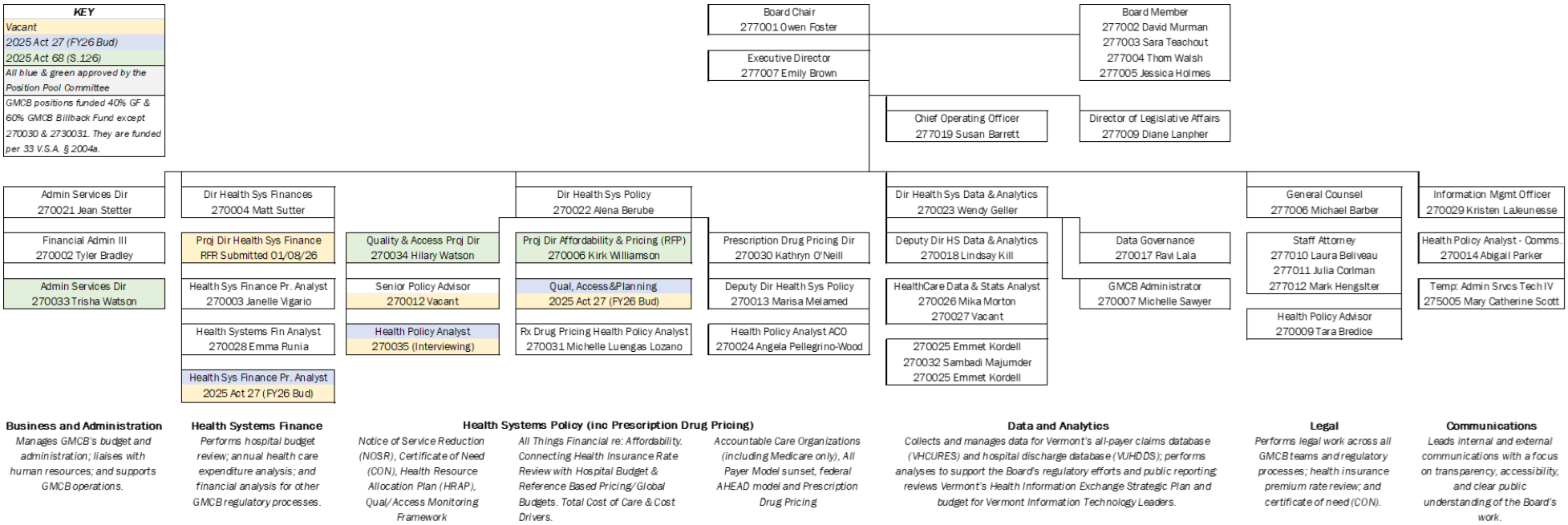
2025	Meeting Topics
Wednesday, January 17	AHEAD Model Update - Potential Vote
Wednesday, January 29	DVHA Presentation on Qualified Health Plan (QHP) Design
Wednesday, February 5	QHP Plan Design – Potential Vote
Wednesday, February 12	SVMC Inpatient Psychiatric CON Hearing
Wednesday, February 19	FY26 Hospital Budget Guidance
	UVMMC FY25 Budget Adjustment Request – Potential Vote
Friday, February 21	UVMMC FY25 Budget Adjustment Request – Potential Vote
Wednesday, March 5	Medicare Breakeven Project
	Guest Presentation on Health Care Quality and Transformation
Wednesday, March 12	FY24 Year-End Actuals Presentation
	FY26 Hospital Budget Guidance – Final Guidance
Monday, March 17	General Advisory Committee (GAC) Meeting
Wednesday, March 26	UVMMC Proposed Settlement Agreement (Public Comment Period)
	FY26 Hospital Budget Guidance – Potential Vote
	Rate Review Affordability Guidance
	Primary Care Advisory Group (PCAG) Meeting
Wednesday, April 2	UVMMC Proposed Settlement Agreement – Executive Session
	Rate Review Affordability Guidance – Potential Vote
Friday, April 4	UVMMC Proposed Settlement Agreement – Potential Vote

Monday, April 21	Data Governance Council Meeting
Wednesday, April 23	Primary Care Advisory Group (PCAG) Meeting
Wednesday, April 30	AHEAD Discussion – Executive Session
Wednesday, May 21	Second Quarter Financials and Actuals
	Vermont Community Hospital Financial Update – FY25 Q2
Wednesday, May 28	Hospital Quality Presentation
Tuesday, June 3	Data Governance Council Meeting
Monday, June 9	General Advisory Committee (GAC) Meeting
Wednesday, June 11	NVRH FY25 Budget Adjustment – Potential Vote
Tuesday, June 17	Primary Care Advisory Group (PCAG) Meeting
Monday, July 21	QHP Rate Review Hearing – MVP
Wednesday, July 23	QHP Rate Review Hearing – BCBSVT
Thursday, July 24	Rate Review Public Comment Forum
	Potential Carryover Date for Rate Review Hearings
Wednesday, July 30	Hospital Budget Review hearings
	Rate Review deliberations
	FY26 Hospital Budget Hearing Exemptions – Potential Vote
Tuesday, August 5	Fy26 Hospital Budget Hearings – Mt. Ascutney and SVMC
	FY26 Hospital Budget Requests and Staff Preliminary Analyses
Wednesday, August 6	Fy26 Hospital Budget Hearings – UVMMC, CVMC, Brattleboro Memorial, Rutland Regional
Monday, August 11	Fy26 Hospital Budget Hearings – UVM Health Network
Tuesday, August 12	Fy26 Hospital Budget Hearings – Northwestern and Gifford

Wednesday, August 13	FY26 Hospital Budget Hearings – Springfield Hospital and Copley Hospital
Tuesday, August 19	Data Governance Council Meeting
Wednesday, August 20	CVMC FY24 Hospital Budget Enforcement
Wednesday, August 27	Staff Presentation on FY26 Service Line Changes and Notice of Service Reduction Policy
	Springfield Hospital FY24 Hospital Budget Enforcement
	Notice of Service Reduction Policy Overview
Wednesday, September 3	Rutland Regional Medical Center FY23 Enforcement Settlement – Potential Vote
	Fy26 Hospital Budget Review Staff Recommendations
Monday, September 8	Notice of Service Reduction Policy Discussion
Wednesday, September 10	FY26Hospital Budget Review Staff Recommendations
	Hospital Budget Review Deliberations and Vote
Friday, September 12	Hospital Budget Review Deliberations and Vote
Monday, September 15	Notice of Service Reduction Policy – Potential Vote
Wednesday, October 8	Discussion of RHTP Application and AHS Transformation Initiatives
	ACO Regulatory Update and Rule Review
Wednesday, October 15	AHEAD Update and Strategy Discussion (Part II)
	Primary Care Advisory Group (PCAG) Meeting
Wednesday, October 22	ACO Regulatory Update and Rule Review – Potential Vote
Wednesday, November 5	Draft Revisions to GMCB Rule 3.000 – Hospital Budget Review
	Data Governance Council Charter Updates – Potential Vote
Wednesday, November 19	Hospital Budget Review Rule – Potential Vote
	Notice of Service Reduction Policy Updates – Potential Vote

Friday, December 5	Brattleboro Retreat Presentation
	Rutland Regional Medical Center – Notice of Service Reduction Hearing
Friday, December 12	Brattleboro Retreat FY26 Budget – Staff Analysis, Recommendation, and Potential Vote
	Rutland Regional Medical Center – Notice of Service Reduction Deliberations and Vote
Monday, December 15	General Advisory Committee (GAC) Meeting
Wednesday, December 17	Hospital 340B Reporting Guidance – Potential Vote
	Northwestern Medical Center FY26 Budget Adjustment – Staff Recommendation and Board Vote

Appendix B: Organizational Chart



GMCB Organizational Chart

Appendix C: GMCB Budget

GMCB Budget Appropriations

Green Mountain Care Board Budget	FY24 Base Budget[22]	FY25 Base Budget[23]	FY25 2024 Act 134 Sec. 1 (c)&(d)	FY26 Base Budget[24]	FY26 2025 Act 68 Sec. 18. (c)&(d)
Total Budget	$ 8,539,233	$ 8,795,410	$ 495,000	$ 10,266,826	$ 1,212,500
General Fund	$ 3,392,339	$ 3,494,109	$ 0	$ 3,970,074	$ 755,000
GMCB Regulatory & Admin Fund	$ 5,146,894	$ 5,301,301	$ 0	$ 6,015,340	$ 307,500
Evidence-Based Education and Advertising Fund	$ 0	$ 0	$ 495,000	$ 281,412	$ 0
Health IT-Fund	$ 0	$ 0	$ 0	$ 0	$ 0
Other Special Funds	$ 0	$ 0	$ 0	$ 0	$ 150,000
Interdepartmental Transfer	$ 0	$ 0	$ 0	$ 0	$ 0
Federal Fund	$ 0	$ 0	$ 0	$ 0	$ 0

2025 Act 27 B.345 includes the following new base budget items:

- $281,412 Evidence-Based Education and Advertising Fund for the two permanent classified positions created in 2024 Act 134 Sec. 1. (c)(1) and per 33 V.S.A. §2004a funded for the Green Mountain Care Board's prescription drug cost regulation initiatives.
- $300,000 General Fund and $450,000 GMCB Billback Fund for three (new) positions from the position pool and contract funding.

2025 Act 68 Sec. 18 (c)(1) and (d). The Green Mountain Care Board, in consultation with its own technical advisory groups and other State agencies, shall explore and create a framework and methodology for implementing a program to regulate the cost of prescription drugs for Vermont consumers and Vermont's health care system.

[22] 2023 Act 78 B.345
[23] 2024 Act 113 B.345
[24] 2025 Act 27 B.345

The Board shall consider options for and likely impacts of regulating the cost of prescription drugs, including:

1. the experiences of states that have developed prescription drug affordability boards;
2. the Centers for Medicare and Medicaid Services' development and operation of the Medicare Drug Price Negotiation Program;
3. other promising federal and state strategies for lowering prescription drug costs;
4. the Board's existing authority to set rates, adopt rules, and establish technical advisory groups;
5. the likely return on investment of the most promising program options;
6. the potential impacts on Vermonters' access to medications; and
7. the impact of implementing a program to regulate the costs of prescription drugs on other State agencies and on the private sector.

Appendix D: Board Member Biographies

GMCB was created by the Vermont Legislature in 2011. It is an independent group of five Vermonters who, with their staff, are charged with ensuring that changes in the health care system improve quality while stabilizing costs. Nominated by a broad-based committee and appointed by the Governor, GMCB includes:

Owen Foster, J.D., Board Chair

Owen Foster served as an assistant United States attorney in the United States Attorney's Office for the District of Vermont for eight years, where he was the healthcare fraud coordinator and ethics officer. Prior to joining the United States Attorney's Office, he was a securities litigation associate for seven years at Dechert, LLP. Owen was born and raised in Middlebury, Vermont and graduated from the University of Vermont in 2001, and from Columbia Law School in 2007. Originally appointed by Governor Phil Scott in 2022, Chair Foster was reappointed for a term that ends in September 2030.

Jessica Holmes, Ph.D.

Jessica Holmes is a Professor of Health Economics and Public Policy and Director of Global Health at Middlebury College. Her teaching portfolio includes courses in Microeconomics, Health Economics and Public Policy, Social Issues and Public Policy, and the Economics of Sin. She has published several articles in areas such as philanthropy, economic development, health economics, labor economics and pedagogy. Prior to joining the Middlebury faculty, she worked as a litigation consultant for National Economic Research Associates, conducting economic analyses for companies facing lawsuits involving securities fraud, product liability, and intellectual property. Jessica received her undergraduate degree from Colgate University and her PhD in Economics from Yale University. She is a past Trustee of Porter Medical Center, having served as Board Secretary and Co-chair of the Strategy Committee. Jessica lives in Cornwall, Vermont. Appointed by Governor Peter Shumlin for a term beginning on October 8, 2014, and ending on September 30, 2020. Reappointed by Governor Phil Scott for a second term ending in 2026.

David Murman, M.D.

David Murman currently works as an emergency medical clinician at Central Vermont Medical Center (CVMC). Prior to his current position, he was an emergency physician and co-director of emergency ultrasound at the University of Vermont Medical Center, an emergency physician at Baystate Medical Center, and completed emergency

residency at Boston Medical Center. Throughout his career, Dr. Murman has been active on finance and operations committees as well as medical student and resident education. He received a B.S. in psychology and his Doctor of Medicine from Tufts University. Before attending medical school, Murman worked in non-profit education/intervention programs for underserved youth, cardiac surgery clinical research, and public health research in Botswana. Murman's appointment begins October 1, 2022, for a term expiring September 30, 2028.

Thom Walsh, Ph.D., MS, MSPT

Thom Walsh is a Professor of the Practice of Health Policy at Dartmouth College, where he teaches Health Systems & Policy at the Geisel Medical and Tuck Business schools. He has authored two books and numerous articles on different aspects of the U.S. healthcare system. His commentaries have appeared in The American Prospect, Washington Monthly, The Atlantic, and other national outlets. Before his appointment, Thom was the co-founder and Chief Strategy Officer of Cardinal Point Health Solutions, a national consulting firm. His background includes direct patient care as a board-certified Physical Therapist specializing in Orthopedics. Governor Phil Scott appointed Thom for a six-year term ending in December 2027.

Sara Teachout, M.U.P.

Sara Teachout brings decades of experience in healthcare policy and fiscal analysis from both the private and public sectors prior to joining the Green Mountain Care Board. She spent eight years in government and media relations at Blue Cross and Blue Shield of Vermont and 16 years as a fiscal analyst with the Legislative Joint Fiscal Office. She holds a master's degree from the Robert F. Wagner School of Public Service at New York University, and a bachelor's degree from the University of Vermont. Sara was appointed by Governor Phil Scott for a term beginning on July 28, 2025.

Emily Brown, J.D., Executive Director

Emily Brown became GMCB's Executive Director in August 2025. She previously served as Vermont's Deputy Commissioner of Insurance at the Department of Financial Regulation, where she managed the Insurance Division and led initiatives to improve access, affordability, and accountability in Vermont's insurance system. An attorney with deep policy and regulatory expertise, Emily has held leadership roles at the state and national level, including with the National Association of Insurance Commissioners. She

holds a law degree from Vermont Law School and a bachelor's degree in political science from New York University.

Appendix E: Glossary

ACO	Accountable Care Organization
AHS	Agency of Human Services
APCD	All -Payer Claims Database
APM	All-Payer Model
CMMI	Center for Medicare and Medicaid Innovation
CON	Certificate of Need
DVHA	Department of Vermont Health Access
ESRD	End Stage Renal Disease
FY	Fiscal Year
GMCB	Green Mountain Care Board
GMSC	Green Mountain Surgery Center
HRAP	Health Resource Allocation Plan
MARC	Medicaid Advisory Rate Case
MRI	Magnetic Resonance Imaging
NPR	Net Patient Revenue
NOSR	Notice of Service Reduction
ORCA	Onion River Community Access
PCAG	Primary Care Advisory Group
QHP	Qualified Health Plan
RFP	Request for Proposals
RHSTF	Rural Health Services Task Force
SASH	Support and Services at Home
TCOC	Total Cost of Care
VELSC	Vermont Eye Surgery and Laser Center
VHIE	Vermont Health Information Exchange
VITL	Vermont Information Technology Leaders
VHCURES	Vermont Health Care Uniform Reporting and Evaluation System
VUHDDS	Vermont Uniform Hospital Discharge Data Set

(end of report)