S.53

An act relating to determining the proportion of health care spending allocated to primary care

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. PRIMARY CARE; FINDINGS

The General Assembly finds that:

(1) Primary care, especially care that incorporates mental health and substance use disorder services, is critical for sustaining a productive community.

(2) Primary care provides a setting in which patients can present a wide range of health problems for appropriate attention and, in most cases, can expect that their problems will be resolved without referral.

(3) Primary care providers and practices assist patients in navigating the health care system, including by providing referrals to other health care providers for appropriate services.

(4) Primary care providers and practices facilitate an ongoing relationship between patients and clinicians and foster participation by patients in shared decision-making about their health and their care.

(5) Primary care provides opportunities for disease prevention, health promotion, and early detection of health conditions.

(6) Primary care helps build bridges between personal health care services and patients' families and communities that can assist in meeting

patients' health care needs.

(7) In order to maximize the benefits of comprehensive primary care, it is essential to maintain consistent, targeted investment over time.

Sec. 2. DEFINITION OF PRIMARY CARE; SPENDING ON PRIMARY CARE; REPORTS

(a) The purpose of this section is to determine the percentage of health care spending that is currently allocated to primary care in order to target any appropriate increases to that percentage.

(b) The Green Mountain Care Board and the Department of Vermont Health Access shall jointly identify, in consultation with health insurers, hospitals, federally qualified health centers, accountable care organizations, primary care providers, other health care professionals, and other interested stakeholders:

(1) the categories of health care professionals who should be considered primary care providers when the services they deliver primarily constitute primary care services, as determined pursuant to subdivision (2) of this subsection;

(2) the specific procedure codes that should be considered primary care services when billed by a primary care provider, as determined pursuant to subdivision (1) of this subsection;

(3) the categories of non-claims-based payments to primary care

providers and practices, such as payments to Blueprint for Health community health teams, bundled payments, and value-based payments, that should be included when determining the total amount spent on primary care; and

(4) the ways in which these categories and codes are consistent with or differ from the categories and codes of direct and indirect primary care expenditures used by other states to determine their primary care spending and used to determine any national estimates of primary care spending.

(c)(1) Using the categories and codes determined pursuant to subsection (b) of this section, the Green Mountain Care Board and the Department of Vermont Health Access shall determine the percentage of total spending that was allocated to primary care by each of the following in the most recent complete calendar year for which information is available:

(A) each health insurer with 500 or more covered lives for comprehensive, major medical health insurance in this State;

(B) Vermont Medicaid;

(C) the State Employees' Health Benefit Plan;

(D) health benefit plans offered pursuant to 24 V.S.A. § 4947 to entities providing educational services; and

(E) the entire Vermont health care system, to the extent data are available.

(2)(A) The Green Mountain Care Board shall use information from the

Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) to the extent available in determining the percentages required in subdivision (1) of this subsection.

(B) Each entity listed in subdivisions (1)(A)–(D) of this subsection shall provide to the Green Mountain Care Board the entity's non-claims-based primary care expenditures for the most recent complete calendar year for which information is available.

(C) The entities listed in subdivisions (1)(A)–(D) of this subsection, and any other entity with relevant data, shall provide pertinent information in response to all reasonable requests from the Green Mountain Care Board and the Department of Vermont Health Access.

(d) On or before January 15, 2020, the Green Mountain Care Board and the Department of Vermont Health Access shall report to the House Committee on Health Care, to the Senate Committees on Health and Welfare and on Finance, and to each entity listed in subdivisions (c)(1)(A)–(D) of this section:

(1) the percentage of total health care spending that the Board and the Department determined each entity and, to the extent data are available, the health care system as a whole, allocated to primary care pursuant to subsection (c) of this section;

(2) a comparison between the percentages described in subdivision (1) of this subsection and available state and national benchmarks of spending on

primary care, including states with demographics comparable to Vermont's;

(3) a comparison between the percentages described in subdivision (1) of this subsection and existing projections of changes in primary care spending in Vermont through 2022 under the all-payer model, as defined in 18 V.S.A. § 9551; and

(4) an analysis of the potential impacts of different methods of achieving increases in primary care spending in future years on:

(A) health outcomes;

(B) patient satisfaction;

(C) patient access to and the availability of primary, specialty, mental health, and tertiary care services; and

(D) Vermont's progress in implementing the all-payer model.

Sec. 2a. LEGISLATIVE INTENT; NONAPPLICABILITY OF STUDY RESULTS TO HEALTH INSURANCE PLAN DESIGN

It is the intent of the General Assembly that the determinations of which health care providers and services constitute primary care for the purposes of this act should not be considered by any health insurer as a dispositive determination of which providers and services should constitute primary care for purposes of health insurance plan design, including cost-sharing requirements.

Sec. 3. EFFECTIVE DATE

This act shall take effect on passage.