S.197

Introduced by Senators Lyons, Bongartz, Cummings, Gulick, Harrison, Ram Hinsdale, Watson and White

Referred to Committee on

Date:

Subject: Health; health care professionals; primary care; Department of Vermont Health Access; Green Mountain Care Board

Statement of purpose of bill as introduced: This bill proposes to establish a primary care payment reform program in which participating primary care providers would receive a monthly payment from the patient's health insurer or other payer for each participating patient that would cover the patient's routine primary care services for the month without any cost-sharing requirements. The bill would require reports from the Department of Vermont Health Access on expanding the program, from the Green Mountain Care Board on site-neutral reimbursements, from the Agency of Human Services and others on transitioning care from hospitals to community settings, from the Green Mountain Care Board and others on access to claims and hospital discharge data, and from the Office of the State Treasurer on the potential for a regional universal primary care program. The bill would also eliminate the 2027 sunset on a primary care physician scholarship program.

An act relating to establishing a primary care payment reform program

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

Sec. 1. LEGISLATIVE INTENT

It is the intent of the General Assembly to invest in primary care by establishing a streamlined primary care payment system that will promote the public good by increasing access to primary care in order to improve the health of Vermonters and reduce health care system costs.

Sec. 2. 18 V.S.A. § 721 is added to read:

§ 721. PRIMARY CARE PAYMENT REFORM PROGRAM

(a)(1) The Department of Vermont Health Access, in coordination with the Green Mountain Care Board and the Blueprint for Health and in consultation with the Vermont Steering Committee for Comprehensive Primary Health Care and other interested stakeholders, shall develop and implement a primary care payment reform program that will promote the public good by investing in primary care and reducing administrative burdens in order to increase access to care and reduce health system costs.

(2) The primary care payment reform program shall initially be voluntary for primary care practices and shall be funded by allocating a portion of commercial health insurance premiums; a portion of premium equivalents from other participating payers; and, to the extent permitted by federal law, waivers of federal law, and federal initiatives, public funds from Medicare and

Medicaid. Beginning in 2028, all primary care practices shall participate in the program.

(3) The program shall collect and aggregate payments from participating payers in order to provide a capitated, per-member per-month payment to each participating primary care practice to cover all of the routine primary care needs of attributed patients who are covered by participating plans, without any patient cost-sharing requirements.

(b) To the extent that the program includes any practice participation requirements, administrative or documentation requirements, or quality measurements, the Department shall establish them in a manner that streamlines and reduces the administrative burdens on primary care practices imposed by the program and by public and private payers, including aligning with, incorporating, or reducing Blueprint for Health requirements.

(1) The program shall establish not more than 12 quality measures and may require a primary care practice to adopt not more than six of them. Each quality measure shall be claims-derived, patient-centered, appropriate for a primary care setting, and supported by peer-reviewed, evidence-based research indicating that the measure is actionable and that its use will lead to improvements in patient health.

(2) The goals of this subsection are:

(A) to reduce the amount of time that primary care practitioners spend on administrative tasks from an average of 50 percent of practitioner time to an average of 10 percent of practitioner time; and

(B) to reduce the need for administrative staff, as measured by the ratio of administrative staff to clinical staff.

(c) The Department shall adopt by rule a risk-adjusted allocation model for primary care practices participating in the payment reform program that may be informed by previous accountable care organization payment methodologies and may blend base per-member per-month capitated payments with fee-for-service payments as needed for specific primary care services. The allocation shall include a reimbursement model and level that:

(1) accomplishes Vermont's primary care spending target as set forth in subsection (g) of this section;

(2) supports sufficient access to and sustainability of primary care services in Vermont;

(3) incorporates different methodologies as needed to address the unique needs of all practice types, including independent practices, federally qualified health centers and rural health centers, and hospital-based primary care practices;

(4) incorporates a methodology with the flexibility necessary to support and adjust for the different scope of services delivered by different practices;

(5) accounts for the closure of accountable care organizations;

(6) accurately attributes patients to primary care practices;

(7) is sufficient to support practices in offering comprehensive, team-based primary care that includes supports for mental health and social drivers of health; and

(8) to the extent permitted under federal law, does not require individuals covered by participating health plans to pay cost-sharing amounts when receiving routine primary care services from participating primary care providers and practices.

(d) The Department shall operate a payment pool to:

(1) collect the primary care allocation of premiums, premium equivalents, and public program funds due from each payer; and

(2) determine the per capita payments or other payment mechanism to distribute the funds to participating primary care practices.

(e) The Department of Vermont Health Access shall adopt rules in accordance with 3 V.S.A. chapter 25 to implement the primary care payment reform program, including:

(1) determining the scope of the primary care services to be included in the capitated rate and the primary care practices that are eligible for participation in the program;

(2) if using, practice participation requirements, administrative and documentation requirements, and quality measurements, in accordance with subsection (b) of this section;

(3) the risk-adjusted allocation model, in accordance with subsection (c) of this section;

(4) operation of the payment pool, in accordance with subsection (d) of this section;

(5) program parameters that address and mitigate against practices avoiding high-risk patients or otherwise engaging in adverse selection, while also striving to maximize practice eligibility and participation;

(6) definitions of direct and indirect primary care spending and appropriate limits on indirect primary care spending as a percentage of health care spending, as set forth in subdivision (g)(2) of this section; and

(7) benchmarks for determining the program's performance, as set forth in subdivision (g)(3) of this section.

(f) The Agency of Human Services or the Green Mountain Care Board, or both, shall enter into negotiations with the Centers for Medicare and Medicaid Services in order to secure Medicare participation in the primary care payment

reform program. The Agency or Board, or both, shall also conduct outreach to self-funded, nongovernmental employer-sponsored plans regarding opportunities for their voluntary participation in the program and to discuss with interested plans the appropriate allocation of premium equivalents to be paid into the payment pool, which amounts should not unfairly disadvantage individuals covered by fully insured plans, self-funded governmental plans, or public benefit programs.

(g)(1) Implementation of the primary care payment reform program shall increase the proportion of total annual health care spending in Vermont that is spent on primary care, with an initial primary care spending allocation target of 15 percent of total Vermont health care spending to be met not later than January 1, 2029. The Department shall establish a transitional schedule that increases the proportion of primary care spending over time in order to achieve the primary care spending target. The increased spending for primary care shall not result in an increase in total health care spending in Vermont.

(2) The Department shall limit indirect primary care spending, as defined by rule, as a percentage of total direct and indirect primary care spending for purposes of the primary care spending target.

(3) The Department may establish a new, higher primary care spending target after the initial target has been achieved if the Department's analysis determines that the primary care payment reform program has met specific

benchmarks established by the Department by rule, in areas including access to primary care, quality of primary care services delivered, impact on health outcomes, and containment of overall health care costs.

(4) For purposes of the primary care spending allocation target, the Department shall use a definition of primary care services that aligns with the definition used in the 2020 report determining the proportion of health care spending in Vermont that is allocated to primary care, which was submitted to the General Assembly by the Green Mountain Care Board and the Department of Vermont Health Access in accordance with 2019 Acts and Resolves No. 17, Sec. 2, and with the definition of primary care services used by the New England States Consortium Systems Organization (NESCSO).

Sec. 3. PRIMARY CARE PAYMENT REFORM PROGRAM; IMPLEMENTATION DATE; REPORTS

(a) The Department of Vermont Health Access shall begin operating the primary care payment reform program established in Sec. 2 of this act on or before July 1, 2027. Participation in the program shall be voluntary for primary care practices when the program begins, but not later than January 1, 2028, all primary care practices in this State shall be participating.

(b) On or before December 15, 2026, the Department of Vermont Health Access, in coordination with the Green Mountain Care Board, shall report to

the House Committee on Health Care, the Senate Committee on Health and Welfare, and the Health Reform Oversight Committee regarding:

(1) progress in establishing the primary care payment reform program and a timeline for its implementation; and

(2) options for revenue sources and mechanisms, along with an operational and financial plan, for expanding the program not later than January 1, 2028, to any patient of a participating practice, regardless of type of the individual's health coverage or coverage status.

Sec. 4. VERMONT CLINICIAN LANDSCAPE; SITE-NEUTRAL REIMBURSEMENTS; REPORTS

On or before January 1, 2027, the Green Mountain Care Board shall report to the House Committee on Health Care and the Senate Committee on Health and Welfare with:

(1) an updated version of the Board's 2017 Vermont Clinician Landscape Study report that reflects the current climate among practicing clinicians in Vermont; and

(2) an updated version of the Board's previous reporting regarding site-neutral reimbursements pursuant to 2015 Acts and Resolves No. 54, Sec. 23; 2016 Acts and Resolves No. 143, Sec. 5; and 2017 Acts and Resolves No. 85, Sec. E.345.1, including the current state of reimbursement differentials based on practice setting and ownership type, along with a description of any

significant efforts that have been implemented since 2017 toward achieving site-neutral reimbursements.

Sec. 5. TRANSITIONING CARE TO COMMUNITY SETTINGS; REPORT

On or before January 15, 2027, the Agency of Human Services, in consultation with the Vermont Steering Committee for Comprehensive Primary Health Care, the Blueprint for Health, the Vermont Association of Hospitals and Health Systems, the Vermont Medical Society, and other interested stakeholders, shall report to the House Committee on Health Care and the Senate Committee on Health and Welfare with recommendations for ways to accelerate the appropriate transition of patients from hospital care to care delivered in a community setting, including ways to reduce the extent to which primary care services are delivered to patients in an inpatient hospital setting following surgery or other acute care, when care delivered by a primary care provider in the community would be as or more effective and less costly. The recommendations shall include opportunities to use community health teams through the Blueprint for Health to coordinate patients' care transitions.

Sec. 6. ACCESS TO CLAIMS AND HOSPITAL DISCHARGE DATA; BILL BACK; REPORT

(a) The Green Mountain Care Board, in collaboration with the Vermont Program for Quality in Health Care (VPQHC), the Vermont Health Information Exchange Steering Committee, and the Office of the Health Care

Advocate, shall consider the existing regulatory structures in place for access to information from the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) and the Vermont Uniform Hospital Discharge Data System (VUHDDS) and recommend ways to improve access to the information for quality improvement purposes while preserving appropriate protections for patient privacy.

(b) The Board, in consultation with VPQHC, shall also recommend any modifications to statute or current practice that are necessary to enable VPQHC's expenses incurred in maintaining the statewide quality assurance system in accordance with 18 V.S.A. § 9416 to be billed back to hospitals and health insurers pursuant to 18 V.S.A. § 9416(c).

(c) On or before January 15, 2027, the Board shall report its findings and recommendations under this section to the House Committee on Health Care and the Senate Committee on Health and Welfare.

Sec. 7. REGIONAL UNIVERSAL PRIMARY CARE PROGRAM; REPORT

The Office of the State Treasurer, in consultation with the Agency of Human Services, shall collaborate with other northeastern states to explore the potential to establish a regional universal primary care program that would be available to all residents of the member states. On or before January 15, 2027, the State Treasurer shall report to the House Committee on Health Care and the Senate Committee on Health and Welfare regarding the Office's outreach

efforts, interest from other northeastern states, any legal or regulatory obstacles identified, and recommendations for next steps.

Sec. 8. 2020 Acts and Resolves No. 155, Sec. 7a, as amended by 2021 Acts and Resolves No. 74, Sec. E.311.2, is further amended to read:

Sec. 7a. ~~SUNSET~~

~~18 V.S.A. § 33 (medical students; primary care) is repealed on July 1, 2027.~~

[Deleted.]

Sec. 9. EFFECTIVE DATE

This act shall take effect on passage.