

1 S.197

2 Introduced by Senators Lyons, Bongartz, Cummings, Gulick, Harrison, Ram

3 Hinsdale, Watson and White

4 Referred to Committee on Health and Welfare

5 Date: January 6, 2026

6 Subject: Health; health care professionals; primary care; Department of

7 Vermont Health Access; Green Mountain Care Board

8 Statement of purpose of bill as introduced: This bill proposes to establish a
9 primary care payment reform program in which participating primary care
10 providers would receive a monthly payment from the patient's health insurer
11 or other payer for each participating patient that would cover the patient's
12 routine primary care services for the month without any cost-sharing
13 requirements. The bill would require reports from the Department of Vermont
14 Health Access on expanding the program, from the Green Mountain Care
15 Board on site-neutral reimbursements, from the Agency of Human Services
16 and others on transitioning care from hospitals to community settings, from the
17 Green Mountain Care Board and others on access to claims and hospital
18 discharge data, and from the Office of the State Treasurer on the potential for a
19 regional universal primary care program. The bill would also eliminate the
20 2027 sunset on a primary care physician scholarship program.

1 ~~An act relating to establishing a primary care payment reform program~~

~~An act relating to payment reform for primary care~~

An act relating to reform for primary care

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

3 ~~Sec. 1. LEGISLATIVE INTENT~~

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

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

9 § 721. PRIMARY CARE PAYMENT REFORM PROGRAM

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

17 (2) The primary care payment reform program shall initially be
18 voluntary for primary care practices and shall be funded by allocating a
19 portion of commercial health insurance premiums; a portion of premium
20 ~~equivalents from other participating payers; and, to the extent permitted by~~

1 ~~federal law, waivers of federal law, and federal initiatives, public funds from~~
2 Medicare and Medicaid. Beginning in 2028, all primary care practices shall
3 participate in the program.

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

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

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

1 (2) The goals of this subsection are:

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

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

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

12 The allocation shall include a reimbursement model and level that:

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

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

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

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

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

4 (6) accurately attributes patients to primary care practices;

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

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

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

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

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

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

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

4 ~~(2) defining, practice participation requirements, administrative and~~
5 ~~documentation requirements, and quality measurements, in accordance with~~
6 ~~subsection (b) of this section;~~

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

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

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

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

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

19 ~~(f) The Agency of Human Services or the Green Mountain Care Board, or~~
20 ~~both, shall enter into negotiations with the Centers for Medicare and Medicaid~~
21 ~~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~~

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

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

12 Sec. 3. PRIMARY CARE PAYMENT REFORM PROGRAM;

13 IMPLEMENTATION DATE; REPORTS

14 (a) The Department of Vermont Health Access shall begin operating the
15 primary care payment reform program established in Sec. 2 of this act on or
16 before July 1, 2027. Participation in the program shall be voluntary for
17 primary care practices when the program begins, but not later than January 1,
18 2028, all primary care practices in this State shall be participating.

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

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

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

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

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

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

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

17 (2) an updated version of the Board's previous reporting regarding site-
18 neutral reimbursements pursuant to 2015 Acts and Resolves No. 54, Sec. 23;
19 2016 Acts and Resolves No. 143, Sec. 5; and 2017 Acts and Resolves No. 85,
20 Sec. E.345.1, including the current state of reimbursement differentials based
21 ~~on practice setting and ownership type, along with a description of any~~

1 ~~significant efforts that have been implemented since 2017 toward achieving~~
2 site neutral reimbursements.

3 Sec. 5. TRANSITIONING CARE TO COMMUNITY SETTINGS; REPORT

4 On or before January 15, 2027, the Agency of Human Services, in
5 consultation with the Vermont Steering Committee for Comprehensive
6 Primary Health Care, the Blueprint for Health, the Vermont Association of
7 Hospitals and Health Systems, the Vermont Medical Society, and other
8 interested stakeholders, shall report to the House Committee on Health Care
9 and the Senate Committee on Health and Welfare with recommendations for
10 ways to accelerate the appropriate transition of patients from hospital care to
11 care delivered in a community setting, including ways to reduce the extent to
12 which primary care services are delivered to patients in an inpatient hospital
13 setting following surgery or other acute care, when care delivered by a primary
14 care provider in the community would be as or more effective and less costly.

15 The recommendations shall include opportunities to use community health
16 teams through the Blueprint for Health to coordinate patients' care transitions.

17 Sec. 6. ACCESS TO CLAIMS AND HOSPITAL DISCHARGE DATA;

18 BILL BACK; REPORT

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

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

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

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

15 Sec. 7. REGIONAL UNIVERSAL PRIMARY CARE PROGRAM; REPORT

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

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

3 Sec. 8. 2020 Acts and Resolves No. 155, Sec. 7a, as amended by 2021 Acts
4 and Resolves No. 74, Sec. E.211.2, is further amended to read:

5 Sec. 7a. SUNSET

6 18 V.S.A. § 33 (medical students; primary care) is repealed on July 1, 2027.

7 [Deleted.]

8 Sec. 9. EFFECTIVE DATE

9 ~~This act shall take effect on passage.~~

~~Sec. 1. LEGISLATIVE INTENT~~

~~*It is the intent of the General Assembly to invest in primary through streamlined primary care payments that build on the Blueprint for Health and 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. chapter 13, subchapter 1 is amended to read:~~

~~Subchapter 1. Blueprint for Health~~

~~§ 701. DEFINITIONS~~

~~As used in this chapter:~~

~~(1) “Blueprint for Health” or “Blueprint” means the State’s program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management.~~

~~***~~

~~(8) “Health insurance plan” has the same meaning as means a major medical insurance plan as defined in 8 V.S.A. § 4011.~~

~~(9) “Health insurer” shall have the same meaning as in section 9402 of this title means any person that offers, issues, renews, or administers a health insurance plan or other health benefit plan in this State and includes, to the extent permitted under federal law, third party administrators that administer~~

~~health benefit plan offering coverage in this State or that provide administrative services only for a health benefit plan offering coverage in this State.~~

* * *

§ 706. HEALTH INSURER PARTICIPATION; PAYMENTS TO PRACTICES

(a) ~~As set forth in 8 V.S.A. § 4025, health insurance plans shall be consistent with the Blueprint for Health as determined by the Commissioner of Financial Regulation.~~

(b)(1) ~~Health insurers shall participate in the Blueprint for Health as a condition of doing business in this State as provided for in this section and in 8 V.S.A. § 4025.~~

~~(2) In order to facilitate development of the sustainable payment models necessary for the Blueprint's success, health insurers shall submit to the Agency of Human Services at least quarterly, or more frequently upon the Agency's request, all information that the Director of the Blueprint deems necessary to perform a comprehensive fiscal analysis of the total cost of care within Vermont and to implement one or more payment models that address health care capacity, volume, quality, and clinical outcomes.~~

(c)(1) ~~The Blueprint payment reform methodologies shall include per-person per-month payments to ~~medical home~~ participating practices, including medical homes and primary care providers, by each health insurer and Medicaid for their attributed patients and for contributions to the shared costs of operating Blueprint initiatives, including the community health teams. Per-person per-month payments to practices shall be:~~

~~(A) based on the official National Committee for Quality Assurance's Physician Practice Connections-Patient Centered Medical Home (NCQA PPC-PCMH) score or another quality standard identified by the Director of the Blueprint in consultation with the Blueprint Payment Implementation Workgroup, to the extent practicable and shall be;~~

~~(B) provided in addition to their normal a practice's typical fee-for-service or other payments; and~~

~~(C) from health insurers, in amounts at least equal to Medicaid payments beginning in 2027.~~

(2) ~~Consistent with recommendations of the Blueprint Executive Committee, the Director of the Blueprint may recommend to the Commissioner of Vermont Health Access Secretary of Human Services changes to the payment amounts or to the payment reform methodologies described in subdivision (1)~~

~~of this subsection, including by providing for enhanced payment to health care professional practices that operate as a medical home, including medical homes and primary care naturopathic physicians' practices; payment toward the shared costs for community health teams; or other payment methodologies required by the Centers for Medicare and Medicaid Services (CMS) for participation by Medicaid or Medicare. In formulating recommendations, the Director shall strive to achieve or maintain parity across payers and payment methodologies and to adjust payment methodologies annually as needed to adequately support practices in maintaining NCQA PCMH status or meeting other requirements for participation in Blueprint programs.~~

~~(3) Health insurers shall modify payment methodologies and amounts to health care professionals and providers as required for the establishment of the model described in sections 703–705 of this title and this section, including any requirements specified by the Centers for Medicare and Medicaid Services (CMS) in approving federal participation in the model to ensure consistency of payment methods in the model.~~

~~(4) In the event that the Secretary of Human Services is denied permission from the Centers for Medicare and Medicaid Services (CMS) to include financial participation by Medicare, health insurers shall not be required to cover the costs associated with individuals covered by Medicare.~~

~~(d) ~~A~~ A health insurer may appeal a decision to require a particular payment methodology or payment amount to the Commissioner of Vermont Health Access Secretary of Human Services or designee, who shall provide a hearing in accordance with 3 V.S.A. chapter 25. A health insurer aggrieved by the decision of the Commissioner Secretary or designee may appeal to the Superior Court for the Washington District within 30 days after the Commissioner issues his or her Secretary or designee issues a decision.~~

~~* * *~~

§ 710. PRIMARY CARE SPENDING TARGETS

~~The Agency of Human Services shall establish a target for the amount of per-person per-month spending on Vermont residents that should be for primary care services and shall develop a transitional schedule that increases that target over time. Targets may be adjusted to reflect payer-specific differences, such as age and health status. The increased spending shall be directed to the per-person per-month payments established in section 706(c) of this chapter.~~

~~Sec. 3. BLUEPRINT PAYMENTS TO PRACTICES, PRIMARY CARE,
REPORT~~

~~On or before January 1, 2027, the Director of the Blueprint for Health, in consultation with the Blueprint Executive Committee and the Vermont Steering Committee for Comprehensive Primary Health Care, shall report to the House Committee on Health Care and the Senate Committee on Health and Welfare regarding changes to the payment amounts or payment reform methodologies, or both, that are necessary to transition the Blueprint's per-person per-month payments to primary care practices to include payment for the routine primary care needs of attributed patients who are covered by participating health plans. The report shall:~~

- ~~(1) define which services should be considered routine primary care;~~
- ~~(2) address any differences in methodology for different practice types;~~
- ~~(3) make recommendations regarding risk-adjustment and attribution methodologies;~~
- ~~(4) describe the ways in which the methodology will balance capacity, volume, quality, and outcomes;~~
- ~~(5) include mechanisms for ensuring that health plans make accurate and appropriate payments to primary care practices in a timely manner;~~
- ~~(6) make recommendations regarding participation or quality measurement requirements, or both;~~
- ~~(7) provide an analysis of including cost-sharing amounts for individuals covered by participating health plans in the methodology, including the extent to which such inclusion would be permissible for a high-deductible health plan without losing its eligibility to be paired with a health savings account;~~
- ~~(8) provide an analysis of ways to incorporate a primary care spending allocation target into the methodology; and~~
- ~~(9) provide an operational plan and a description of any additional legislation needed in order to implement the methodology not later than January 1, 2028.~~

~~Sec. 4. PRIMARY CARE SPENDING; AGENCY OF HUMAN SERVICES;
REPORT~~

~~On or before January 1, 2027, the Agency of Human Services, in consultation with the Green Mountain Care Board, shall report to the House Committee on Health Care and the Senate Committee on Health and Welfare the baseline per-person per-month spending on primary care services for~~

~~Vermont residents overall and by each health insurer, third-party administrator administering a health plan or providing administrative services only for a health plan, Medicaid, and Medicare. The Agency shall use the definition of primary care providers and services from the Advancing Healthcare Efficiency through Accountable Design (AHEAD) Model or the definition of primary care services used by the New England States Consortium Systems Organization (NESCSO).~~

~~Sec. 5. PRIMARY CARE SPENDING TARGETS; REPORT~~

~~On or before January 1, 2028, the Agency of Human Services shall report to the House Committee on Health Care and the Senate Committee on Health and Welfare the per-person per-month primary care spending targets developed pursuant to 18 V.S.A. § 710, as added by Sec. 2 of this act, as well as the proposed transitional schedule for increasing that target over time, any recommendations for payer-specific adjustments to the targets, and any additional legislation that is needed to implement and enforce the primary care spending targets and 18 V.S.A. § 710.~~

~~Sec. 6. 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. 7. 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, Bi-State Primary Care Association, 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. The Agency shall incorporate the recommendations into the Health Care Delivery Strategic Plan as appropriate.~~

~~Sec. 8. 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. 9. 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. 10. 8 V.S.A. § 4092(i) is amended to read:~~

~~(i)(1) On a periodic basis but not less than once per calendar year, each health insurer shall notify all individuals covered under its health insurance plans of any changes in pharmaceutical coverage and provide access to the preferred drug list maintained by the health insurer or its pharmacy benefit manager.~~

~~(2) Not less than 60 days prior to removing a prescription drug from its formulary or from the formulary maintained by a pharmacy benefit manager its behalf, a health insurer shall notify all individuals covered under its health insurance plans who filled a prescription for that prescription drug within the previous 12-month period that coverage for the drug will be discontinued and of the date on which the coverage will end.~~

~~Sec. 11. EFFECTIVE DATE~~

~~This act shall take effect on passage.~~

Sec. 1. LEGISLATIVE INTENT; PURPOSES

(a) It is the intent of the General Assembly to invest in primary care and to establish a program of universal primary care that:

(1) is accessible to and affordable for all Vermonters; and

(2) will promote the public good by:

(A) improving the patient experience of care;

(B) improving population health;

(C) reducing costs; and

(D) improving the well-being of clinicians and staff.

(b) The purposes of this bill are to:

(1) obtain the information necessary to develop a framework for implementation of universal primary care;

(2) optimize the Blueprint for Health;

(3) determine whether the Blueprint is an appropriate mechanism through which to provide universal primary care; and

(4) explore other approaches to universal primary care and whether they may be more suitable than the Blueprint in meeting Vermont's needs.

Sec. 2. 18 V.S.A. chapter 13, subchapter 1 is amended to read:

Subchapter 1. Blueprint for Health

§ 701. DEFINITIONS

As used in this chapter:

(1) "Blueprint for Health" or "Blueprint" means the State's program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management.

** * **

(8) "Health insurance plan" ~~has the same meaning as~~ means a major medical insurance plan as defined in 8 V.S.A. § 4011.

(9) "Health insurer" ~~shall have the same meaning as in section 9402 of this title~~ means any person that offers, issues, renews, or administers a health insurance plan or other health benefit plan in this State and includes, to the extent permitted under federal law, third-party administrators that administer a health benefit plan offering coverage in this State or that provide

administrative services only for a health benefit plan offering coverage in this State.

* * *

§ 706. HEALTH INSURER PARTICIPATION; PAYMENTS TO PRACTICES

(a) As set forth in 8 V.S.A. § 4025, health insurance plans shall be consistent with the Blueprint for Health as determined by the Commissioner of Financial Regulation.

(b)(1) Health insurers shall participate in the Blueprint for Health as a condition of doing business in this State as provided for in this section and in 8 V.S.A. § 4025.

(2) In order to facilitate development of the sustainable payment models necessary for the Blueprint's success, health insurers shall submit to the Agency of Human Services at least quarterly, or more frequently upon the Agency's request, all information that the Director of the Blueprint deems necessary to perform a comprehensive fiscal analysis of the total cost of care within Vermont and to implement one or more payment models that address health care capacity, volume, quality, and clinical outcomes.

(c)(1) The Blueprint payment reform methodologies shall include per-person per-month payments to ~~medical home~~ participating practices, including medical homes and primary care providers, by each health insurer and Medicaid for their attributed patients and for contributions to the shared costs of operating Blueprint initiatives, including the community health teams. Per-person per-month payments to practices shall be:

(A) based on the official National Committee for Quality Assurance's Physician-Practice-Connections-Patient Centered Medical Home (NCQA PPC-PCMH) score or another quality standard identified by the Director of the Blueprint in consultation with the Blueprint Payment Implementation Workgroup, to the extent practicable and shall be;

(B) provided in addition to their normal a practice's typical fee-for-service or other payments; and

(C) from health insurers, in amounts at least equal to Medicaid payments beginning in 2027.

(2) Consistent with recommendations of the Blueprint Executive Committee, the Director of the Blueprint may recommend to the ~~Commissioner of Vermont Health Access~~ Secretary of Human Services changes to the payment amounts or to the payment reform methodologies described in subdivision (1) of this subsection, including by providing for enhanced payment to health care

~~professional practices that operate as a medical home, including medical homes and primary care naturopathic physicians' practices; payment toward the shared costs for community health teams; or other payment methodologies required by the Centers for Medicare and Medicaid Services (CMS) for participation by Medicaid or Medicare. In formulating recommendations, the Director shall strive to achieve or maintain parity across payers and payment methodologies and to adjust payment methodologies annually as needed to adequately support practices in maintaining NCQA PCMH status or meeting other requirements for participation in Blueprint programs.~~

~~(3) Health insurers shall modify payment methodologies and amounts to health care professionals and providers as required for the establishment of the model described in sections 703–705 of this title and this section, including any requirements specified by the Centers for Medicare and Medicaid Services (CMS) in approving federal participation in the model to ensure consistency of payment methods in the model.~~

~~(4) In the event that the Secretary of Human Services is denied permission from the Centers for Medicare and Medicaid Services (CMS) to include financial participation by Medicare, health insurers shall not be required to cover the costs associated with individuals covered by Medicare.~~

~~(d) ~~A~~ A health insurer may appeal a decision to require a particular payment methodology or payment amount to the ~~Commissioner of Vermont Health Access~~ Secretary of Human Services or designee, who shall provide a hearing in accordance with 3 V.S.A. chapter 25. ~~A~~ A health insurer aggrieved by the decision of the ~~Commissioner~~ Secretary or designee may appeal to the Superior Court for the Washington District within 30 days after the ~~Commissioner issues his or her~~ Secretary or designee issues a decision.~~

* * *

~~Sec. 3. BLUEPRINT PAYMENTS TO PRACTICES; PRIMARY CARE; REPORT~~

~~(a) On or before January 15, 2027, the Director of the Blueprint for Health, in consultation with the Blueprint Executive Committee and the Vermont Steering Committee for Comprehensive Primary Health Care, shall report to the House Committee on Health Care and the Senate Committee on Health and Welfare regarding changes to the payment amounts or payment methodologies, or both, that would be necessary to transition the Blueprint's per-person per-month payments to primary care practices to include payment for the routine primary care needs of attributed patients who are covered by participating health plans. The report shall:~~

(1) establish definitions of “primary care services” and “primary care provider” and define which services should be considered routine primary care;

(2) address any differences in methodology for different practice types;

(3) make recommendations regarding risk-adjustment and attribution methodologies;

(4) describe the ways in which the methodology will balance capacity, volume, quality, and outcomes;

(5) include mechanisms for ensuring that health plans make accurate and appropriate payments to primary care practices in a timely manner;

(6) make recommendations regarding participation or quality measurement requirements, or both;

(7) provide an analysis of including cost-sharing amounts for individuals covered by participating health plans in the methodology, including the extent to which such inclusion would be permissible for a high-deductible health plan without losing its eligibility to be paired with a health savings account;

(8) provide an analysis of ways to incorporate a primary care spending allocation target into the methodology;

(9) provide an operational plan, a description of any additional legislation needed in order to implement the methodology, and a proposed timeline for implementation; and

(10) provide a description of the ways in which the Blueprint can optimize the delivery of the services within each of its current initiatives, the costs associated with enhancing each initiative to its highest level, and the amount of additional per-person per-month spending that would be needed to support the enhanced delivery of these services across all Blueprint initiatives.

(b) The Director of the Blueprint or designee shall be available upon request from July through December 2026 to provide updates to the Health Reform Oversight Committee on the development of the report required by subsection (a) of this section.

Sec. 3a. FUNDING FOR BLUEPRINT FOR HEALTH; HEALTH CARE CLAIMS TAX; REPORT

On or before January 15, 2027, the Agency of Human Services, in consultation with the Department of Taxes, shall recommend to the House Committees on Health Care and on Ways and Means and the Senate Committees on Health and Welfare and on Finance a process by which funding

for the Blueprint for Health may be transitioned from the mechanisms established in 18 V.S.A. chapter 13, subchapter 1 to the health care claims tax established in 32 V.S.A. chapter 243, as identified in the report that the Director of the Blueprint submitted to the General Assembly in accordance with 2023 Acts and Resolves No. 51, Sec. 5. The Agency's recommendations shall include any modifications to the tax rates established in 32 V.S.A. § 10402 that would be necessary to fully support the operation of the Blueprint, as amended by Sec. 2 of this act, and a potential timeline for implementation.

**Sec. 4. PRIMARY CARE SPENDING; AGENCY OF HUMAN SERVICES;
REPORT**

On or before January 15, 2027, the Agency of Human Services, in consultation with the Green Mountain Care Board, shall report to the House Committee on Health Care and the Senate Committee on Health and Welfare the baseline per-person per-month spending on primary care services for Vermont residents overall and by each health insurer, third-party administrator administering a health plan or providing administrative services only for a health plan, Medicaid, and Medicare. The Agency shall use the definitions of primary care providers and services established pursuant to Sec. 3(a) of this act.

Sec. 5. PRIMARY CARE SPENDING TARGETS; REPORT

The Agency of Human Services shall establish a target for the amount of per-person per-month spending on Vermont residents that should be for primary care services and shall develop a transitional schedule that increases the target over time. On or before January 1, 2028, the Agency of Human Services shall provide the spending targets and transitional schedule, as well as any recommendations for adjustments to the targets that are needed to reflect payer-specific differences, such as age and health status, to the House Committee on Health Care and the Senate Committee on Health and Welfare.

**Sec. 6. DISTRIBUTION OF DUTIES FOR HEALTH CARE
REGULATION AND HEALTH CARE REFORM; REPORT**

(a) The Agency of Human Services, Green Mountain Care Board, and Department of Financial Regulation, in collaboration with the Office of the Health Care Advocate, shall evaluate the roles their respective organizations play in health care regulation and health care reform in this State, including with respect to hospital transformation efforts, health insurance rate review, management of the Office of Health Care Reform, operation of the Blueprint for Health, and administration of other programs and initiatives. The Agency, Board, and Department shall identify where each health care regulation and

health care reform function should be most appropriately located in order to optimize collaboration, information sharing, and efficient operations in furtherance of attaining the principles for health care reform set forth in 2011 Acts and Resolves No. 48 and as codified at 18 V.S.A. § 9371; improving access to high-quality, affordable health care services; accomplishing health care transformation; and safeguarding hospital sustainability and insurer solvency.

(b) On or before January 15, 2027, the Agency, Board, and Department shall each provide specific recommendations on the distribution of responsibilities resulting from their efforts pursuant to subsection (a) of this section, including areas of agreement and disagreement, gaps and overlaps identified, and any legislative changes needed to achieve their preferred organizational structures, to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance. The Agency, Board, and Department shall also be available upon request from July through December 2026 to provide updates to the Health Reform Oversight Committee on their efforts and the development of the report required by subsection (a) of this section.

Sec. 7. 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, Bi-State Primary Care Association, 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. The Agency shall incorporate the recommendations into the Statewide Health Care Delivery Strategic Plan as appropriate.

Sec. 8. 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. 9. 8 V.S.A. § 4092(i) is amended to read:

(i)(1) On a periodic basis but not less than once per calendar year, each health insurer shall notify all individuals covered under its health insurance plans of any changes in pharmaceutical coverage and provide access to the preferred drug list maintained by the health insurer or its pharmacy benefit manager.

(2) Not less than 60 days prior to removing a prescription drug from its formulary or from the formulary maintained by a pharmacy benefit manager on its behalf, a health insurer shall notify all individuals covered under its health insurance plans who filled a prescription for that prescription drug within the previous 12-month period that coverage for the drug will be discontinued and of the date on which the coverage will end.

Sec. 10. EFFECTIVE DATE

This act shall take effect on passage.