S.197

An act relating to reform for primary care

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

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) ~~An~~ 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. ~~An~~ 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.

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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;

1 (6) make recommendations regarding participation or quality
2 measurement requirements, or both;
3 (7) provide an analysis of including cost-sharing amounts for individuals
4 covered by participating health plans in the methodology, including the extent
5 to which such inclusion would be permissible for a high-deductible health plan
6 without losing its eligibility to be paired with a health savings account;
7 (8) provide an analysis of ways to incorporate a primary care spending
8 allocation target into the methodology;
9 (9) provide an operational plan, a description of any additional
10 legislation needed in order to implement the methodology, and a proposed
11 timeline for implementation; and
12 (10) provide a description of the ways in which the Blueprint can
13 optimize the delivery of the services within each of its current initiatives, the
14 costs associated with enhancing each initiative to its highest level, and the
15 amount of additional per-person per-month spending that would be needed to
16 support the enhanced delivery of these services across all Blueprint initiatives.
17 (b) The Director of the Blueprint or designee shall be available upon
18 request from July through December 2026 to provide updates to the Health
19 Reform Oversight Committee on the development of the report required by
20 subsection (a) of this section.

1 Sec. 3a. FUNDING FOR BLUEPRINT FOR HEALTH; HEALTH CARE
2 CLAIMS TAX; REPORT
3 On or before January 15, 2027, the Agency of Human Services, in
4 consultation with the Department of Taxes, shall recommend to the House
5 Committees on Health Care and on Ways and Means and the Senate
6 Committees on Health and Welfare and on Finance a process by which funding
7 for the Blueprint for Health may be transitioned from the mechanisms
8 established in 18 V.S.A. chapter 13, subchapter 1 to the health care claims tax
9 established in 32 V.S.A. chapter 243, as identified in the report that the
10 Director of the Blueprint submitted to the General Assembly in accordance
11 with 2023 Acts and Resolves No. 51, Sec. 5. The Agency's recommendations
12 shall include any modifications to the tax rates established in 32 V.S.A.
13 § 10402 that would be necessary to fully support the operation of the
14 Blueprint, as amended by Sec. 2 of this act, and a potential timeline for
15 implementation.
16 Sec. 4. PRIMARY CARE SPENDING; AGENCY OF HUMAN SERVICES;
17 REPORT
18 On or before January 15, 2027, the Agency of Human Services, in
19 consultation with the Green Mountain Care Board, shall report to the House
20 Committee on Health Care and the Senate Committee on Health and Welfare
21 the baseline per-person per-month spending on primary care services for

1 Vermont residents overall and by each health insurer, third-party administrator
2 administering a health plan or providing administrative services only for a
3 health plan, Medicaid, and Medicare. The Agency shall use the definitions of
4 primary care providers and services established pursuant to Sec. 3(a) of this
5 act.
6 Sec. 5. PRIMARY CARE SPENDING TARGETS; REPORT
7 The Agency of Human Services shall establish a target for the amount of
8 per-person per-month spending on Vermont residents that should be for
9 primary care services and shall develop a transitional schedule that increases
10 the target over time. On or before January 1, 2028, the Agency of Human
11 Services shall provide the spending targets and transitional schedule, as well as
12 any recommendations for adjustments to the targets that are needed to reflect
13 payer-specific differences, such as age and health status, to the House
14 Committee on Health Care and the Senate Committee on Health and Welfare.
15 Sec. 6. DISTRIBUTION OF DUTIES FOR HEALTH CARE
16 REGULATION AND HEALTH CARE REFORM; REPORT
17 (a) The Agency of Human Services, Green Mountain Care Board, and
18 Department of Financial Regulation, in collaboration with the Office of the
19 Health Care Advocate, shall evaluate the roles their respective organizations
20 play in health care regulation and health care reform in this State, including
21 with respect to hospital transformation efforts, health insurance rate review,

1 management of the Office of Health Care Reform, operation of the Blueprint
2 for Health, and administration of other programs and initiatives. The Agency,
3 Board, and Department shall identify where each health care regulation and
4 health care reform function should be most appropriately located in order to
5 optimize collaboration, information sharing, and efficient operations in
6 furtherance of attaining the principles for health care reform set forth in 2011
7 Acts and Resolves No. 48 and as codified at 18 V.S.A. § 9371; improving
8 access to high-quality, affordable health care services; accomplishing health
9 care transformation; and safeguarding hospital sustainability and insurer
10 solvency.
11 (b) On or before January 15, 2027, the Agency, Board, and Department
12 shall each provide specific recommendations on the distribution of
13 responsibilities resulting from their efforts pursuant to subsection (a) of this
14 section, including areas of agreement and disagreement, gaps and overlaps
15 identified, and any legislative changes needed to achieve their preferred
16 organizational structures, to the House Committee on Health Care and the
17 Senate Committees on Health and Welfare and on Finance. The Agency,
18 Board, and Department shall also be available upon request from July through
19 December 2026 to provide updates to the Health Reform Oversight Committee
20 on their efforts and the development of the report required by subsection (a) of
21 this section.

1 Sec. 7. TRANSITIONING CARE TO COMMUNITY SETTINGS; REPORT
2 On or before January 15, 2027, the Agency of Human Services, in
3 consultation with the Vermont Steering Committee for Comprehensive
4 Primary Health Care, the Blueprint for Health, the Vermont Association of
5 Hospitals and Health Systems, the Vermont Medical Society, Bi-State Primary
6 Care Association, and other interested stakeholders, shall report to the House
7 Committee on Health Care and the Senate Committee on Health and Welfare
8 with recommendations for ways to accelerate the appropriate transition of
9 patients from hospital care to care delivered in a community setting, including
10 ways to reduce the extent to which primary care services are delivered to
11 patients in an inpatient hospital setting following surgery or other acute care,
12 when care delivered by a primary care provider in the community would be as
13 or more effective and less costly. The recommendations shall include
14 opportunities to use community health teams through the Blueprint for Health
15 to coordinate patients' care transitions. The Agency shall incorporate the
16 recommendations into the Statewide Health Care Delivery Strategic Plan as
17 appropriate.
18 Sec. 8. REGIONAL UNIVERSAL PRIMARY CARE PROGRAM; REPORT
19 The Office of the State Treasurer, in consultation with the Agency of
20 Human Services, shall collaborate with other northeastern states to explore the
21 potential to establish a regional universal primary care program that would be

1 available to all residents of the member states. On or before January 15, 2027,
2 the State Treasurer shall report to the House Committee on Health Care and the
3 Senate Committee on Health and Welfare regarding the Office's outreach
4 efforts, interest from other northeastern states, any legal or regulatory obstacles
5 identified, and recommendations for next steps.
6 Sec. 9. 8 V.S.A. § 4092(i) is amended to read:
7 (i)(1) On a periodic basis but not less than once per calendar year, each
8 health insurer shall notify all individuals covered under its health insurance
9 plans of any changes in pharmaceutical coverage and provide access to the
10 preferred drug list maintained by the health insurer or its pharmacy benefit
11 manager.
12 (2) Not less than 60 days prior to removing a prescription drug from its
13 formulary or from the formulary maintained by a pharmacy benefit manager on
14 its behalf, a health insurer shall notify all individuals covered under its health
15 insurance plans who filled a prescription for that prescription drug within the
16 previous 12-month period that coverage for the drug will be discontinued and
17 of the date on which the coverage will end.
18 Sec. 10. EFFECTIVE DATE
19 This act shall take effect on passage.