

1 S.197

2 An act relating to payment reform for primary care

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

4 Sec. 1. LEGISLATIVE INTENT

5 It is the intent of the General Assembly to invest in primary through
6 streamlined primary care payments that build on the Blueprint for Health and
7 will promote the public good by increasing access to primary care in order to
8 improve the health of Vermonters and reduce health care system costs.

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

10 Subchapter 1. Blueprint for Health

11 § 701. DEFINITIONS

12 As used in this chapter:

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

17 * * *

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

20 (9) “Health insurer” ~~shall have the same meaning as in section 9402 of~~
21 this title means any person that offers, issues, renews, or administers a health

1 insurance plan or other health benefit plan in this State and includes, to the
2 extent permitted under federal law, third-party administrators that administer a
3 health benefit plan offering coverage in this State or that provide
4 administrative services only for a health benefit plan offering coverage in this
5 State.

6 * * *

7 § 706. HEALTH INSURER PARTICIPATION; PAYMENTS TO
8 PRACTICES

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

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

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

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

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

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

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

16 (2) Consistent with recommendations of the Blueprint Executive
17 Committee, the Director of the Blueprint may recommend to the
18 ~~Commissioner of Vermont Health Access~~ Secretary of Human Services
19 changes to the payment amounts or to the payment reform methodologies
20 described in subdivision (1) of this subsection, including by providing for
21 enhanced payment to health care professional practices ~~that operate as a~~

1 ~~medical home~~, including medical homes and primary care naturopathic
2 ~~physicians~~² practices; payment toward the shared costs for community health
3 teams; or other payment methodologies required by the Centers for Medicare
4 and Medicaid Services (CMS) for participation by Medicaid or Medicare. In
5 formulating recommendations, the Director shall strive to achieve or maintain
6 parity across payers and payment methodologies and to adjust payment
7 methodologies annually as needed to adequately support practices in
8 maintaining NCQA PCMH status or meeting other requirements for
9 participation in Blueprint programs.

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

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

20 (d) ~~An~~ A health insurer may appeal a decision to require a particular
21 payment methodology or payment amount to the ~~Commissioner of Vermont~~

1 ~~Health Access~~ Secretary of Human Services or designee, who shall provide a
2 hearing in accordance with 3 V.S.A. chapter 25. ~~An~~ A health insurer
3 aggrieved by the decision of the ~~Commissioner~~ Secretary or designee may
4 appeal to the Superior Court for the Washington District within 30 days after
5 the ~~Commissioner~~ Secretary or designee issues a decision.

6 * * *

7 § 710. PRIMARY CARE SPENDING TARGETS

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

15 Sec. 3. BLUEPRINT PAYMENTS TO PRACTICES; PRIMARY CARE;

16 REPORT

17 On or before January 1, 2027, the Director of the Blueprint for Health, in
18 consultation with the Blueprint Executive Committee and the Vermont
19 Steering Committee for Comprehensive Primary Health Care, shall report to
20 the House Committee on Health Care and the Senate Committee on Health and
21 Welfare regarding changes to the payment amounts or payment reform

1 methodologies, or both, that are necessary to transition the Blueprint's per-
2 person per-month payments to primary care practices to include payment for
3 the routine primary care needs of attributed patients who are covered by
4 participating health plans. The report shall:

5 (1) define which services should be considered routine primary care;

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

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

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

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

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

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

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

1 (9) provide an operational plan and a description of any additional
2 legislation needed in order to implement the methodology not later than
3 January 1, 2028.

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

6 On or before January 1, 2027, the Agency of Human Services, in
7 consultation with the Green Mountain Care Board, shall report to the House
8 Committee on Health Care and the Senate Committee on Health and Welfare
9 the baseline per-person per-month spending on primary care services for
10 Vermont residents overall and by each health insurer, third-party administrator
11 administering a health plan or providing administrative services only for a
12 health plan, Medicaid, and Medicare. The Agency shall use the definition of
13 primary care providers and services from the Advancing Healthcare Efficiency
14 through Accountable Design (AHEAD) Model or the definition of primary
15 care services used by the New England States Consortium Systems
16 Organization (NESCO).

17 Sec. 5. PRIMARY CARE SPENDING TARGETS; REPORT

18 On or before January 1, 2028, the Agency of Human Services shall report to
19 the House Committee on Health Care and the Senate Committee on Health and
20 Welfare the per-person per-month primary care spending targets developed
21 pursuant to 18 V.S.A. § 710, as added by Sec. 2 of this act, as well as the

1 proposed transitional schedule for increasing that target over time, any
2 recommendations for payer-specific adjustments to the targets, and any
3 additional legislation that is needed to implement and enforce the primary care
4 spending targets and 18 V.S.A. § 710.

5 Sec. 6. VERMONT CLINICIAN LANDSCAPE; SITE-NEUTRAL
6 REIMBURSEMENTS; REPORTS

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

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

13 (2) an updated version of the Board's previous reporting regarding site-
14 neutral reimbursements pursuant to 2015 Acts and Resolves No. 54, Sec. 23;
15 2016 Acts and Resolves No. 143, Sec. 5; and 2017 Acts and Resolves No. 85,
16 Sec. E.345.1, including the current state of reimbursement differentials based
17 on practice setting and ownership type, along with a description of any
18 significant efforts that have been implemented since 2017 toward achieving
19 site-neutral reimbursements.

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 Health Care Delivery Strategic Plan as appropriate.

17 Sec. 8. REGIONAL UNIVERSAL PRIMARY CARE PROGRAM; REPORT

18 The Office of the State Treasurer, in consultation with the Agency of
19 Human Services, shall collaborate with other northeastern states to explore the
20 potential to establish a regional universal primary care program that would be
21 available to all residents of the member states. On or before January 15, 2027,

1 the State Treasurer shall report to the House Committee on Health Care and the
2 Senate Committee on Health and Welfare regarding the Office's outreach
3 efforts, interest from other northeastern states, any legal or regulatory obstacles
4 identified, and recommendations for next steps.

5 Sec. 9. 2020 Acts and Resolves No. 155, Sec. 7a, as amended by 2021 Acts
6 and Resolves No. 74, Sec. E.311.2, is further amended to read:

7 Sec. 7a. ~~SUNSET~~

8 ~~18 V.S.A. § 33 (medical students; primary care) is repealed on July 1, 2027.~~

9 [Deleted.]

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

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

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

- 1 Sec. 11. EFFECTIVE DATE
- 2 This act shall take effect on passage.