House Proposal of Amendment

S. 197

An act relating to payment reform for primary care

The House proposes to the Senate to amend the bill by striking out all after the enacting clause and inserting in lieu thereof the following:

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.

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§ 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;

(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 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.

and that after passage the title of the bill be amended to read: "An act relating to reform for primary care"