

1 TO THE HOUSE OF REPRESENTATIVES:

2 The Committee on Health Care to which was referred Senate Bill No. 197
3 entitled “An act relating to payment reform for primary care” respectfully
4 reports that it has considered the same and recommends that the House propose
5 to the Senate that the bill be amended by striking out all after the enacting
6 clause and inserting in lieu thereof the following:

7 Sec. 1. LEGISLATIVE INTENT; **PURPOSE**

8 **(a) It is the intent of the General Assembly to invest in primary care**
9 **through streamlined primary care payments that build on the Blueprint for**
10 **Health and to establish a program of universal primary care that:**

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

12 **(2) will promote the public good by:**

13 **(A) improving the patient experience of care;**

14 **(B) improving population health;**

15 **(C) reducing costs; and**

16 **(D) improving the well-being of clinicians and staff, increasing**
17 **access to primary care in order to improve the health of Vermonters and reduce**
18 **health care system costs.**

19 **(b) The purpose of this bill is to obtain the information necessary to**

20 **develop a framework for implementation of universal primary care,**

21 **including optimizing the Blueprint for Health to determine whether it is**

1 **an appropriate mechanism through which to provide universal primary**
2 **care.**

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

4 Subchapter 1. Blueprint for Health

5 § 701. DEFINITIONS

6 As used in this chapter:

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

11 * * *

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

14 (9) “Health insurer” ~~shall have the same meaning as in section 9402 of~~
15 this title means any person that offers, issues, renews, or administers a health
16 insurance plan or other health benefit plan in this State and includes, to the
17 extent permitted under federal law, third-party administrators that administer a
18 health benefit plan offering coverage in this State or that provide
19 administrative services only for a health benefit plan offering coverage in this
20 State.

21 * * *

1 § 706. HEALTH INSURER PARTICIPATION; PAYMENTS TO
2 PRACTICES

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

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

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

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

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

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

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

10 (2) Consistent with recommendations of the Blueprint Executive
11 Committee, the Director of the Blueprint may recommend to the
12 ~~Commissioner of Vermont Health Access~~ Secretary of Human Services
13 changes to the payment amounts or to the payment reform methodologies
14 described in subdivision (1) of this subsection, including by providing for
15 enhanced payment to health care professional practices ~~that operate as a~~
16 ~~medical home~~, including medical homes and primary care ~~naturopathic~~
17 ~~physicians'~~ practices; payment toward the shared costs for community health
18 teams; or other payment methodologies required by the Centers for Medicare
19 and Medicaid Services (CMS) for participation by Medicaid or Medicare. In
20 formulating recommendations, the Director shall strive to achieve or maintain
21 parity across payers and payment methodologies and to adjust payment

1 methodologies annually as needed to adequately support practices in
2 maintaining NCQA PCMH status or meeting other requirements for
3 participation in Blueprint programs.

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

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

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

21 * * *

1 § 710. PRIMARY CARE SPENDING TARGETS

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

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

10 REPORT

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

- 1 **(1) establish definitions of “primary care services” and “primary**
- 2 **care provider” and** define which services should be considered routine
- 3 primary care;
- 4 (2) address any differences in methodology for different practice types;
- 5 (3) make recommendations regarding risk-adjustment and attribution
- 6 methodologies;
- 7 (4) describe the ways in which the methodology will balance capacity,
- 8 volume, quality, and outcomes;
- 9 (5) include mechanisms for ensuring that health plans make accurate
- 10 and appropriate payments to primary care practices in a timely manner;
- 11 (6) make recommendations regarding participation or quality
- 12 measurement requirements, or both;
- 13 (7) provide an analysis of including cost-sharing amounts for individuals
- 14 covered by participating health plans in the methodology, including the extent
- 15 to which such inclusion would be permissible for a high-deductible health plan
- 16 without losing its eligibility to be paired with a health savings account;
- 17 **(8) establish a target for the amount of per-person per-month**
- 18 **spending on Vermont residents that should be for primary care services**
- 19 **and develop a transitional schedule that increases that target over time,**
- 20 **adjusting targets as needed to reflect payer-specific differences, such as**
- 21 **age and health status;**

1 (9) provide an analysis of ways to incorporate a primary care spending
2 allocation target into the methodology; and

3 (10) provide an operational plan, and a description of any additional
4 legislation needed in order to implement the methodology not later than
5 January 1, 2028, and a proposed timeline for implementation; and

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

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

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 from the Advancing Healthcare Efficiency
5 through Accountable Design (AHEAD) Model or the definition of primary
6 care services used by the New England States Consortium Systems
7 Organization (NESCSO) established pursuant to Sec. 3(a) of this act.

8 **Sec. 5. PRIMARY CARE SPENDING TARGETS; REPORT**

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

17 **Sec. 5. DISTRIBUTION OF DUTIES FOR HEALTH CARE**

18 **REGULATION AND HEALTH CARE REFORM; REPORT**

19 **(a) The Agency of Human Services, Green Mountain Care Board, and**
20 **Department of Financial Regulation, in collaboration with the Office of**
21 **the Health Care Advocate, shall evaluate the roles their respective**

1 **organizations play in health care regulation and health care reform in this**
2 **State, including with respect to hospital transformation efforts, health**
3 **insurance rate review, management of the Office of Health Care Reform,**
4 **operation of the Blueprint for Health, and administration of other**
5 **programs and initiatives. The Agency, Board, and Department shall**
6 **collectively determine where each health care regulation and health care**
7 **reform function should be most appropriately located in order to optimize**
8 **collaboration, information sharing, and efficient operations in furtherance**
9 **of attaining the principles for health care reform set forth in 2011 Acts**
10 **and Resolves No. 48 and as codified at 18 V.S.A. § 9371; establishing**
11 **universal primary care; improving access to high-quality, affordable**
12 **health care services; accomplishing health care transformation; and**
13 **safeguarding hospital sustainability and insurer solvency.**

14 **(b) On or before January 15, 2027, the Agency, Board, and**
15 **Department shall provide their joint recommendations, including areas of**
16 **agreement and disagreement, gaps and overlaps identified, and any**
17 **legislative changes needed, to the House Committee on Health Care and**
18 **the Senate Committees on Health and Welfare and on Finance. The**
19 **Agency, Board, and Department shall also be available upon request from**
20 **July through December 2026 to provide updates to the Health Reform**

1 **Oversight Committee on their efforts and the development of the report**
2 **required by subsection (a) of this section.**

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

5 On or before January 15, 2027, the Green Mountain Care Board shall report
6 to the House Committee on Health Care and the Senate Committee on Health
7 and Welfare with:

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

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

18 Sec. 7. TRANSITIONING CARE TO COMMUNITY SETTINGS; REPORT

19 On or before January 15, 2027, the Agency of Human Services, in
20 consultation with the Vermont Steering Committee for Comprehensive
21 Primary Health Care, the Blueprint for Health, the Vermont Association of

1 Hospitals and Health Systems, the Vermont Medical Society, Bi-State Primary
2 Care Association, and other interested stakeholders, shall report to the House
3 Committee on Health Care and the Senate Committee on Health and Welfare
4 with recommendations for ways to accelerate the appropriate transition of
5 patients from hospital care to care delivered in a community setting, including
6 ways to reduce the extent to which primary care services are delivered to
7 patients in an inpatient hospital setting following surgery or other acute care,
8 when care delivered by a primary care provider in the community would be as
9 or more effective and less costly. The recommendations shall include
10 opportunities to use community health teams through the Blueprint for Health
11 to coordinate patients’ care transitions. The Agency shall incorporate the
12 recommendations into the Health Care Delivery Strategic Plan as appropriate.

13 **Sec. 8. UNIVERSAL PRIMARY CARE EFFORTS IN OTHER STATES;**

14 **REPORT**

15 **The Office of Health Care Reform in the Agency of Human Services**
16 **shall examine efforts that have been undertaken or are currently**
17 **underway in other states to establish universal primary care, including the**
18 **methodologies, funding mechanisms, implementation plans, and timelines**
19 **considered or pursued, or both, and any legal or regulatory obstacles**
20 **identified and potential solutions explored. On or before January 15,**
21 **2027, the Office shall report to the House Committee on Health Care and**

1 **the Senate Committee on Health and Welfare with the most promising**
2 **opportunities identified and lessons learned and how those compare with**
3 **the approaches to universal primary care contemplated in this act.**

4 Sec. 9. REGIONAL UNIVERSAL PRIMARY CARE PROGRAM; REPORT

5 The Office of the State Treasurer, in consultation with the Agency of
6 Human Services, shall collaborate with other northeastern states to explore the
7 potential to establish a regional universal primary care program that would be
8 available to all residents of the member states. On or before January 15, 2027,
9 the State Treasurer shall report to the House Committee on Health Care and the
10 Senate Committee on Health and Welfare regarding the Office’s outreach
11 efforts, interest from other northeastern states, any legal or regulatory obstacles
12 identified, and recommendations for next steps.

13 Sec. 10. 2020 Acts and Resolves No. 155, Sec. 7a, as amended by 2021 Acts
14 and Resolves No. 74, Sec. E.311.2, is further amended to read:

15 Sec. 7a. ~~SUNSET~~

16 ~~18 V.S.A. § 33 (medical students; primary care) is repealed on July 1, 2027.~~

17 [Deleted.]

18 Sec. 11. 8 V.S.A. § 4092(i) is amended to read:

19 (i)(1) On a periodic basis but not less than once per calendar year, each
20 health insurer shall notify all individuals covered under its health insurance
21 plans of any changes in pharmaceutical coverage and provide access to the

1 preferred drug list maintained by the health insurer or its pharmacy benefit
2 manager.

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

9 Sec. 12. EFFECTIVE DATE

10 This act shall take effect on passage.

11 and that after passage the title of the bill be amended to read: “An act relating
12 to _____”

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17 (Committee vote: _____)

18

19

Representative _____

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FOR THE COMMITTEE