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**S**

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

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

11 (2) will promote the public good by:

12 (A) improving the patient experience of care;

13 (B) improving population health;

14 (C) reducing costs; and

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

16 (b) The purposes of this bill ~~is~~ **are** to**:**

17 **(1)** obtain the information necessary to develop a framework for
18 implementation of universal primary care~~, including optimizing~~**;**

19 (2) **optimize** the Blueprint for Health ~~to determine~~**;**

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

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

(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.

* * *

1 Sec. 3. BLUEPRINT PAYMENTS TO PRACTICES; PRIMARY CARE;
2 REPORT
3 (a) On or before January 15, 2027, the Director of the Blueprint for Health,
4 in consultation with the Blueprint Executive Committee and the Vermont
5 Steering Committee for Comprehensive Primary Health Care, shall report to
6 the House Committee on Health Care and the Senate Committee on Health and
7 Welfare regarding changes to the payment amounts or payment ~~reform~~
8 methodologies, or both, that ~~are~~ **would be** necessary to transition the
9 Blueprint's per-person per-month payments to primary care practices to
10 include payment for the routine primary care needs of attributed patients who
11 are covered by participating health plans. The report shall:
12 (1) establish definitions of "primary care services" and "primary care
13 provider" and define which services should be considered routine primary
14 care;
15 (2) address any differences in methodology for different practice types;
16 (3) make recommendations regarding risk-adjustment and attribution
17 methodologies;
18 (4) describe the ways in which the methodology will balance capacity,
19 volume, quality, and outcomes;
20 (5) include mechanisms for ensuring that health plans make accurate
21 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) establish a target for the amount of per-person per-month spending on Vermont residents that should be for primary care services and develop a transitional schedule that increases that target over time, adjusting targets as needed to reflect payer-specific differences, such as age and health status;~~

(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;

(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**;** **and**

1 **(11) recommend a process for moving to the health care claims tax**
2 **established in 32 V.S.A. chapter 243 as the mechanism to fund the**
3 **Blueprint as identified in the report submitted to the General Assembly in**
4 **accordance with 2023 Acts and Resolves No. 51, Sec. 5, including**
5 **providing a potential timeline for implementation**.
6 (b) The Director of the Blueprint or designee shall be available upon
7 request from July through December 2026 to provide updates to the Health
8 Reform Oversight Committee on the development of the report required by
9 subsection (a) of this section.
10 Sec. 4. PRIMARY CARE SPENDING; AGENCY OF HUMAN SERVICES;
11 REPORT
12 On or before January 15, 2027, the Agency of Human Services, in
13 consultation with the Green Mountain Care Board, shall report to the House
14 Committee on Health Care and the Senate Committee on Health and Welfare
15 the baseline per-person per-month spending on primary care services for
16 Vermont residents overall and by each health insurer, third-party administrator
17 administering a health plan or providing administrative services only for a
18 health plan, Medicaid, and Medicare. The Agency shall use the definitions of
19 primary care providers and services established pursuant to Sec. 3(a) of this
20 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 ~~report~~ **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 ~~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. 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

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

~~On or before January 15, 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

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 **Statewide** Health Care Delivery Strategic Plan as
13 appropriate.
14 ~~Sec. 8. UNIVERSAL PRIMARY CARE EFFORTS IN OTHER STATES;~~
15 ~~REPORT~~
16 ~~The Office of Health Care Reform in the Agency of Human Services shall~~
17 ~~examine efforts that have been undertaken or are currently underway in other~~
18 ~~states to establish universal primary care, including the methodologies, funding~~
19 ~~mechanisms, implementation plans, and timelines considered or pursued, or~~
20 ~~both, and any legal or regulatory obstacles identified and potential solutions~~
21 ~~explored. On or before January 15, 2027, the Office shall report to the House~~

1 Committee on Health Care and the Senate Committee on Health and Welfare
2 with the most promising opportunities identified and lessons learned and how
3 those compare with the approaches to universal primary care contemplated in
4 this act.
5 Sec. 8. REGIONAL UNIVERSAL PRIMARY CARE PROGRAM; REPORT
6 The Office of the State Treasurer, in consultation with the Agency of
7 Human Services, shall collaborate with other northeastern states to explore the
8 potential to establish a regional universal primary care program that would be
9 available to all residents of the member states. On or before January 15, 2027,
10 the State Treasurer shall report to the House Committee on Health Care and the
11 Senate Committee on Health and Welfare regarding the Office's outreach
12 efforts, interest from other northeastern states, any legal or regulatory obstacles
13 identified, and recommendations for next steps.
14 Sec. 10. 2020 Acts and Resolves No. 155, Sec. 7a, as amended by 2021 Acts
15 and Resolves No. 74, Sec. E.311.2, is further amended to read:
16 Sec. 7a. SUNSET
17 18 V.S.A. § 33 (medical students; primary care) is repealed on July 1, 2027.
18 [Deleted.]
19 Sec. 9. 8 V.S.A. § 4092(i) is amended to read:
20 (i)(1) On a periodic basis but not less than once per calendar year, each
21 health insurer shall notify all individuals covered under its health insurance

1 plans of any changes in pharmaceutical coverage and provide access to the
2 preferred drug list maintained by the health insurer or its pharmacy benefit
3 manager.
4 (2) Not less than 60 days prior to removing a prescription drug from its
5 formulary or from the formulary maintained by a pharmacy benefit manager on
6 its behalf, a health insurer shall notify all individuals covered under its health
7 insurance plans who filled a prescription for that prescription drug within the
8 previous 12-month period that coverage for the drug will be discontinued and
9 of the date on which the coverage will end.
10 Sec. 10. EFFECTIVE DATE
11 This act shall take effect on passage.
12 and that after passage the title of the bill be amended to read: "An act relating
13 to reform for primary care"
14
15
16
17
18
19 (Committee vote: ___________)

1 _______________________

2 Representative ___________

3 FOR THE COMMITTEE