



S. 197
April 3, 2027

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WHY S. 197 – INCREASE SUSTAINABILITY OF & ACCESS TO PRIMARY CARE



**Primary Care
Investment Target**



**Primary Care
Payment Reform**



**Primary Care
Workforce**

Invest More, Pay Differently Using Vermont's Existing Infrastructure





Primary Care Payment Reform

Step 1: Strengthen What we Have

S. 197 Section 2: Expand Blueprint Patient Centered Medical Home “Add on” Payments

- Expands definition of insurers
- Requires all insurers to contribute at least equally to Medicaid (currently \$4.65 PMPM)
- Strengthens role of Blueprint ED to adjust contributions annually to adequately support practices

Why?

- Implements recommendations from [Act 51 of 2023 report](#) to bring in all payers to support the costs of the Blueprint programs
- Spreads costs of the program more fairly and could *decrease* contributions from QHP plans while increasing investment in baseline practice support payments.
- Based on the Consumer Price Index, the commercial insurer contribution has lost 22% of purchasing power since it was set in 2016, causing strain on practice resources used to keep up with evolving PCMH standards





Primary Care Payment Reform

Step 2: Reimagine Scope of PCMH Payments

S. 197 Section 3: Can PCMH Payments Move from “Add on” to Replacing Fee for Service

- Report by January 1, 2027 **with input from primary care practitioners** how to transition PCMH payments to include paying for routine primary care services
- Allows time for input but also requires an operational plan no later than January 1, 2028

Why?

- We already have trusted multi-payer primary care payment program in Vermont – with attribution and payment methodologies and relationships to primary care practices
- We need further input to get this right – which services should be capitated vs FFS; is this site neutral or different by setting; who makes sure attribution and payment amounts are correct
- Need more than rate-setting – not just higher amounts but paying differently; many PCP practices not overseen by GMCB
- Doesn't require creating a new insurance infrastructure – works with existing insurance model





Primary Care Payment Reform

Step 3: Explore Universal Access

S. 197 Section 3: Can Reimagined PCMH Payment Cover All Patient Cost Sharing

- Study requires an examination of whether cost sharing amounts can be included in the payments to practices

Why?

- Out of pocket costs should not disincentivize seeking primary care services
- Blueprint services are already available to all patients regardless of insurance status - can we expand this to include the routine primary care services covered





Primary Care Investment Target

Section 2, § 710 : The Agency of Human Services shall establish a target for the amount of per-person per-month spending that should be for primary care services

- Shall develop a schedule to increase the investment over time
- Increases shall be directed to the PMPM established

Why?

- In the United States primary care is [under-resourced](#), accounting for 35 percent of health care visits while receiving only about 5 percent of health care expenditures nationally
- When [DVHA/GMCB last measured](#), Vermont payers directed to primary care services 9.2% for Commercial, 24.3% for Medicaid, 6.5% for Medicare - 10.2% overall across payers
- Vermont needs to move beyond a baseline measure of primary care spending to setting a target for the amount of spend
- States that have mandated an increasing minimum percentage of health care dollars be spent on primary care services have achieved an increased investment in primary care, to over 12% in both Rhode Island and Oregon
- Per member per month targets (vs a % of overall spending) normalizes for wide variations in spending by payer – more apples to apples – recommended in recent report by Maryland Health Care Commission on [Primary Care Investment](#)
- Statute should include guardrails regarding where the investment is directed to ensure it meaningfully supports primary care practices





Primary Care Investment Target

Section 4: The Agency of Human Services shall report on baseline per member per month spending on primary care by Vermont residents overall and by each health insurer

- Shall use the definition of primary care services used in the AHEAD Model or New England State Consortium Systems Organization

Why?

- Vermont should use established definitions of primary care spending to:
 - Avoid “relitigating” how we measure primary care spend and what is included
 - To be able to compare more “apples to apples” with other states and between payers
 - To align with the AHEAD Model, if we are participating - AHEAD will also require participating states to establish and meet an all-payer primary care investment target





Primary Care Workforce

Section 9: Strikes Sunset on Medical Student Incentive Scholarship

Why?

- We need the workforce to provide the primary care services!
- Funding currently remains for 11 more scholarship (\$476,770) but statute sunsets program

AHEC Scholars Incentive Scholarship:

\$40K/year in exchange for 1 year
rural service obligation.

AHEC Scholars Incentive Scholarship:

- 25 awards made to date; 24
placements pending
(training not yet completed)

This award meant so much more than just helping to fund my education. It showed me the investment that AHEC is willing to take for rural healthcare to succeed, with the hope for me to return home one day, as a rural pediatrician. They've been there every step of the way, and I am thrilled to have returned to the NEK.

- UVM AHEC Scholarship Recipient



Comments on other sections:

- **Neutral regarding remaining reports in the bill**
- **Section 6 – clinician landscape/site neutral billing – may be less necessary with H. 585**
- **Section 7 – transitioning to community settings**
- **Section 8 – regional UPC**



Questions?

