S.197, An act relating to payment reform for primary care, showing markup from House proposal of amendment

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

Sec. 1. LEGISLATIVE INTENT**; PURPOSES**

It is the intent of the General Assembly to invest in primary ~~through streamlined primary care payments that build on the Blueprint for Health~~ **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 ~~increasing access to primary care in order to improve the health of Vermonters and reduce health care system costs~~**:**

(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.

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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.

* * *

§ 706. HEALTH INSURER PARTICIPATION; PAYMENTS TO

1 PRACTICES
2 (a) As set forth in 8 V.S.A. § 4025, health insurance plans shall be
3 consistent with the Blueprint for Health as determined by the Commissioner of
4 Financial Regulation.
5 (b)(1) Health insurers shall participate in the Blueprint for Health as a
6 condition of doing business in this State as provided for in this section and in 8
7 V.S.A. § 4025.
8 (2) In order to facilitate development of the sustainable payment models
9 necessary for the Blueprint's success, health insurers shall submit to the
10 Agency of Human Services at least quarterly, or more frequently upon the
11 Agency's request, all information that the Director of the Blueprint deems
12 necessary to perform a comprehensive fiscal analysis of the total cost of care
13 within Vermont and to implement one or more payment models that address
14 health care capacity, volume, quality, and clinical outcomes.
15 (c)(1) The Blueprint payment reform methodologies shall include per-
16 person per-month payments to ~~medical home~~ participating practices, including
17 medical homes and primary care providers, by each health insurer and
18 Medicaid for their attributed patients and for contributions to the shared costs
19 of operating Blueprint initiatives, including the community health teams. Per-
20 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 ~~§ 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 1**5**, 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~~ **would be** necessary to transition the
17 Blueprint's per-person per-month payments to primary care practices to
18 include payment for the routine primary care needs of attributed patients who
19 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; ~~and~~

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

1 **(10) provide a description of the ways in which the Blueprint can**
2 **optimize the delivery of the services within each of its current initiatives,**
3 **the costs associated with enhancing each initiative to its highest level, and**
4 **the amount of additional per-person per-month spending that would be**
5 **needed to support the enhanced delivery of these services across all**
6 **Blueprint initiatives.**
7 **(b) The Director of the Blueprint or designee shall be available upon**
8 **request from July through December 2026 to provide updates to the**
9 **Health Reform Oversight Committee on the development of the report**
10 **required by subsection (a) of this section**.
11 **Sec. 3a. FUNDING FOR BLUEPRINT FOR HEALTH; HEALTH CARE**
12 **CLAIMS TAX; REPORT**
13 **On or before January 15, 2027, the Agency of Human Services, in**
14 **consultation with the Department of Taxes, shall recommend to the House**
15 **Committees on Health Care and on Ways and Means and the Senate**
16 **Committees on Health and Welfare and on Finance a process by which**
17 **funding for the Blueprint for Health may be transitioned from the**
18 **mechanisms established in 18 V.S.A. chapter 13, subchapter 1 to the**
19 **health care claims tax established in 32 V.S.A. chapter 243, as identified in**
20 **the report that the Director of the Blueprint submitted to the General**
21 **Assembly in accordance with 2023 Acts and Resolves No. 51, Sec. 5. The**

1 **Agency's recommendations shall include any modifications to the tax**
2 **rates established in 32 V.S.A. § 10402 that would be necessary to fully**
3 **support the operation of the Blueprint, as amended by Sec. 2 of this act,**
4 **and a potential timeline for implementation.**
5 Sec. 4. PRIMARY CARE SPENDING; AGENCY OF HUMAN SERVICES;
6 REPORT
7 On or before January 15, 2027, the Agency of Human Services, in
8 consultation with the Green Mountain Care Board, shall report to the House
9 Committee on Health Care and the Senate Committee on Health and Welfare
10 the baseline per-person per-month spending on primary care services for
11 Vermont residents overall and by each health insurer, third-party administrator
12 administering a health plan or providing administrative services only for a
13 health plan, Medicaid, and Medicare. The Agency shall use the definitions of
14 primary care providers and services ~~from the Advancing Healthcare Efficiency~~
15 ~~through Accountable Design (AHEAD) Model or the definition of primary~~
16 ~~care services used by the New England States Consortium Systems~~
17 ~~Organization (NESCSO)~~ **established pursuant to Sec. 3(a) of this act**.
18 Sec. 5. PRIMARY CARE SPENDING TARGETS; REPORT
19 **The Agency of Human Services shall establish a target for the amount**
20 **of per-person per-month spending on Vermont residents that should be**
21 **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 to the House Committee on Health Care and the Senate Committee on Health and Welfare the per-person per-month primary care~~ **provide the** spending targets ~~developed pursuant to 18 V.S.A. § 710, as added by Sec. 2 of this act, as well as the proposed~~ **and** transitional schedule ~~for increasing that target over time~~, **as well as** 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~~ **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

1 **identify where each health care regulation and health care reform**
2 **function should be most appropriately located in order to optimize**
3 **collaboration, information sharing, and efficient operations in furtherance**
4 **of attaining the principles for health care reform set forth in 2011 Acts**
5 **and Resolves No. 48 and as codified at 18 V.S.A. § 9371; improving access**
6 **to high-quality, affordable health care services; accomplishing health care**
7 **transformation; and safeguarding hospital sustainability and insurer**
8 **solvency.**
9 **(b) On or before January 15, 2027, the Agency, Board, and**
10 **Department shall each provide specific recommendations on the**
11 **distribution of responsibilities resulting from their efforts pursuant to**
12 **subsection (a) of this section, including areas of agreement and**
13 **disagreement, gaps and overlaps identified, and any legislative changes**
14 **needed to achieve their preferred organizational structures, to the House**
15 **Committee on Health Care and the Senate Committees on Health and**
16 **Welfare and on Finance. The Agency, Board, and Department shall also**
17 **be available upon request from July through December 2026 to provide**
18 **updates to the Health Reform Oversight Committee on their efforts and**
19 **the development of the report required by subsection (a) of this section.**
20 ~~Sec. 6. VERMONT CLINICIAN LANDSCAPE; SITE-NEUTRAL~~

1 ~~REIMBURSEMENTS; REPORTS~~

2 ~~On or before January 1, 2027, the Green Mountain Care Board shall report~~

3 ~~to the House Committee on Health Care and the Senate Committee on Health~~

4 ~~and Welfare with:~~

5 ~~(1) an updated version of the Board's 2017 Vermont Clinician~~

6 ~~Landscape Study report that reflects the current climate among practicing~~

7 ~~clinicians in Vermont; and~~

8 ~~(2) an updated version of the Board's previous reporting regarding site-~~

9 ~~neutral reimbursements pursuant to 2015 Acts and Resolves No. 54, Sec. 23;~~

10 ~~2016 Acts and Resolves No. 143, Sec. 5; and 2017 Acts and Resolves No. 85,~~

11 ~~Sec. E.345.1, including the current state of reimbursement differentials based~~

12 ~~on practice setting and ownership type, along with a description of any~~

13 ~~significant efforts that have been implemented since 2017 toward achieving~~

14 ~~site-neutral reimbursements.~~

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

16 On or before January 15, 2027, the Agency of Human Services, in

17 consultation with the Vermont Steering Committee for Comprehensive

18 Primary Health Care, the Blueprint for Health, the Vermont Association of

19 Hospitals and Health Systems, the Vermont Medical Society, Bi-State Primary

20 Care Association, and other interested stakeholders, shall report to the House

21 Committee on Health Care and the Senate Committee on Health and Welfare

1 with recommendations for ways to accelerate the appropriate transition of
2 patients from hospital care to care delivered in a community setting, including
3 ways to reduce the extent to which primary care services are delivered to
4 patients in an inpatient hospital setting following surgery or other acute care,
5 when care delivered by a primary care provider in the community would be as
6 or more effective and less costly. The recommendations shall include
7 opportunities to use community health teams through the Blueprint for Health
8 to coordinate patients' care transitions. The Agency shall incorporate the
9 recommendations into the **Statewide** Health Care Delivery Strategic Plan as
10 appropriate.

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

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

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

1 ~~Sec. 7a. SUNSET~~

2 ~~18 V.S.A. § 33 (medical students; primary care) is repealed on July 1, 2027.~~

3 ~~[Deleted.]~~

4 Sec. 9. 8 V.S.A. § 4092(i) is amended to read:

5 (i)(1) On a periodic basis but not less than once per calendar year, each

6 health insurer shall notify all individuals covered under its health insurance

7 plans of any changes in pharmaceutical coverage and provide access to the

8 preferred drug list maintained by the health insurer or its pharmacy benefit

9 manager.

10 (2) Not less than 60 days prior to removing a prescription drug from its

11 formulary or from the formulary maintained by a pharmacy benefit manager its

12 behalf, a health insurer shall notify all individuals covered under its health

13 insurance plans who filled a prescription for that prescription drug within the

14 previous 12-month period that coverage for the drug will be discontinued and

15 of the date on which the coverage will end.

16 Sec. 11. EFFECTIVE DATE

17 This act shall take effect on passage.

18 **and that after passage the title of the bill be amended to read: "An act**

19 **relating to reform for primary care"**