MVP Health Care Comments

Vermont Senate Bill S.197
An Act Relating to Establishing a Primary Care Payment Reform Program

Senate Committee on Health and Welfare
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I. Introduction and Statement of Interest

MVP Health Care is a not-for-profit regional health plan serving approximately 600,000 members across New York and Vermont, including approximately 40,000 commercial members here in Vermont. Our mission is whole-person health—a commitment that goes beyond managing claims to actively supporting members in living healthier, more empowered lives.

MVP submits these written comments to supplement oral testimony presented before the Senate Committee on Health and Welfare. We support the intent of S.197. Strengthening primary care is the right goal—and a shared one. Vermont's primary care workforce is stretched thin. Too many Vermonters wait weeks for an appointment, manage chronic conditions without adequate support, or turn to emergency departments because they cannot access timely primary care. S.197 takes these problems seriously, and MVP commends the Committee and the bill's sponsors for their leadership.

At the same time, the structural design decisions embedded in this legislation will determine whether it achieves its promise. A payment reform program built on the right foundations—thoughtful definitions, outcome-based accountability, and flexibility for innovation—can accelerate transformation toward a genuinely prevention-focused health system. A program built on the wrong foundations risks doing the opposite: locking in the existing visit-based model, concentrating compliance costs on a shrinking segment of the market, and increasing spending without meaningfully improving health. Once definitions and benchmarks are established in statute and rule, they are difficult to unwind—making these early design decisions especially consequential.

These comments focus on three foundational design questions that must be resolved:

- What counts as primary care, and how broadly should the definition be drawn?
- Are we paying for activity or outcomes—and how do we build outcome accountability into the program from the start?
- How do we preserve flexibility and innovation while ensuring that policy design keeps pace with a rapidly evolving primary care landscape?

II. Patients are the Center of Gravity

Every design decision should begin with a simple question: What do Vermonters need from their primary care system?

The answer is not complicated. Whether healthy, managing a chronic illness, or recovering from disease, Vermonters want the same basic things from their health system:

- To stay healthy when they are well.
- To return to health when they are sick.
- To prevent their condition from deteriorating over time.

Vermont has an opportunity to design a modernized primary care system around what actually keeps people healthy—not just around what generates a billable code. Getting the design right means being deliberate about definitions, payment structure, accountability, and equity. We address each in turn.

III. Definition Matters More Than the Percentage

A. The Definition Is the Mandate

S.197 establishes a 15 percent primary care spending target and creates a state-administered payment pool to aggregate payer contributions. The percentage has received considerable attention. But the more consequential design decision is what counts as primary care for purposes of measuring investment and assessing compliance.

The bill currently anchors its definition to the one used in the 2020 report submitted by the Green Mountain Care Board and DVHA, and aligns with the NESCSO definition. We strongly urge Vermont to think carefully about whether that definition is sufficient to capture the full scope of what effective, modern primary care looks like in 2026 and what it could look like in 2040.

If primary care is defined narrowly—limited to traditional office-based encounters by a licensed physician or nurse practitioner—the spending requirement will reinforce a visit-based model that most health experts agree is already insufficient. Vermonters who live in rural areas, who work non-traditional hours, or who face mobility limitations will not be well served by a system whose primary unit of investment is the 20-minute in-person office visit.

If instead the definition reflects where primary care is going—team-based, prevention-focused, technology-enabled, community-supported, proactive rather than reactive—it can help accelerate transformation. The definition is, in practical effect, the mandate. Before locking in any benchmark, Vermont must be precise about what it is actually purchasing. If the program is designed around visit volume and billable encounters, the system will predictably respond by producing more visits—regardless of whether health outcomes improve.

B. The Full Scope of Effective Primary Care

Modern, effective primary care is not a place. It is a longitudinal relationship—sustained over time between a patient and a care team that knows that patient's history, preferences, goals, and risks.

For that relationship to work, the tools that support health between visits must be part of the picture. Vermont should explicitly confirm that primary care spending—for purposes of any benchmark—includes:

- Health coaching and lifestyle medicine programs that address the root drivers of chronic disease, including nutrition, physical activity, stress, and substance use.
- Behavioral health services integrated into primary care settings, not just when a behavioral health provider is co-located in the same physical office.
- Remote patient monitoring and digital health tools that extend the care team's reach between visits and support real-time clinical decision-making.
- Community health workers and care navigators who connect patients to social services, housing support, and food resources — the social determinants that drive a significant proportion of health outcomes.
- Care coordination infrastructure and patient outreach that is currently classified as administrative overhead rather than clinical spending.

We also note that prescription drugs are a key tool in managing chronic conditions. Currently, S.197 does not appear to contemplate prescription drugs as part of the definition. A $50 statin that saves a $100,000 heart attack is textbook primary care. If the goal is to measure success of the global spend investment in prevention and primary care, prescription drugs should be captured as well.

C. The Last Mile of Primary Care: Where Prevention Succeeds or Fails

Whole-person health is not achieved at the moment a diagnosis is made or a prescription is written. It is achieved—or lost—in what happens after the visit.

The hardest part of health care is not identifying risk. It is the last mile: whether a patient actually changes their diet after being told they are prediabetic; whether they take their blood pressure medication consistently; whether they engage with their care team between visits; whether they have the support, tools, and follow-up necessary to sustain change over time. Prevention succeeds or fails there.

A primary care system designed primarily around episodic, in-office encounters is poorly equipped to address the last mile. Office visits can identify risk, but they do not, on their own, change behavior, reinforce adherence, or provide sustained support. Effective prevention requires longitudinal relationships, proactive outreach, and infrastructure that supports patients between visits—not just during them.

This is why investments in care coordination, health coaching, behavioral health integration, remote monitoring, and community-based supports are not ancillary to primary care—they are core primary care infrastructure. These tools enable care teams to stay connected to patients in daily life, where habits are formed and health trajectories are determined.

If S.197 is designed to measure success primarily through visits, screenings, or documentation, it will reinforce a model that identifies risk without reliably reducing it. If instead the bill recognizes and supports the infrastructure required to succeed in the last mile, Vermont can build a primary care system that does more than detect disease—it helps people change its course. This is what MVP

describes as empowered well-being: equipping patients with the tools, support, and engagement necessary to manage their health between visits, not just during appointments.

D. The Invisible Investment Problem

The 15 percent benchmark as currently defined will be calculated primarily from claims data. This creates a structural problem: many of the most impactful primary care investments do not generate claims today. These services will often not occur in a physician's office, and/or aren't billable under traditional fee-for-service payment models.

Health coaching, care coordination infrastructure, digital tools, community health worker programs, patient onboarding, and health and social needs assessments are all proven levers of health improvement—and none of them reliably generate a claim. If the benchmark measures only what flows through the claims system, Vermont will end up measuring activity rather than investment. The program will reward billable visits, not preventive infrastructure.

S.197 delegates the task of defining direct and indirect primary care spending and establishing limits on indirect spending. The Committee should provide clearer direction in the statutory language that non-claims investments among payers and practices—when they are evidence-based, clinically purposeful, and directed at improving health outcomes—must be counted, including investments made by the payers themselves to support this infrastructure. Without that guardrail, the rulemaking process may default to a narrower definition that undermines the bill's own goals.

IV. From Sick Care to Well Care: Payment Must Reflect Where Primary Care Is Going

For decades, the American health system has been organized around sick care: an appointment, a diagnosis, a prescription. That model has always been better at treating illness than preventing it. The evidence is overwhelming—chronic disease burden, rising rates of preventable hospitalizations, and the persistent difficulty of managing conditions like diabetes, hypertension, and depression without sustained behavioral support all reflect the limits of the episodic visit model.

The pandemic accelerated a shift that was already underway. Telehealth became normalized. Remote monitoring expanded. Patients grew comfortable engaging with their care teams digitally between visits. Providers adopted new workflows. The tools now exist to support health between visits — not just during them. S.197 must codify those tools as core primary care infrastructure, not optional enhancements.

A. Meeting Vermonters Where They Are

One size does not fit all in the primary care landscape, and S.197 should not pretend otherwise.

A working parent in Burlington may need a same-day telehealth visit at 7 p.m. A retired farmer in the Northeast Kingdom may need a trusted provider who does home visits. An elderly patient managing multiple chronic conditions may benefit most from remote monitoring that prevents a crisis before it happens.

In a rural state, prevention cannot depend on a 40-minute drive during business hours. A system designed around the traditional in-person office visit as the default— and only— unit of primary care will consistently miss the patients who are hardest to reach and most at risk.

The pandemic demonstrated that care can be delivered flexibly without sacrificing quality. S.197 should reward engagement and outcomes across all modalities—in-person, telehealth, in-home, digital, and community-based—rather than privileging any single setting. Flexibility is not about convenience. It is about access.

B. Personalized Prevention and the Limits of Population Health

Health care has invested heavily in population health—managing cohorts, improving aggregate metrics, and tracking performance at the panel level. That work matters. Accountability at the population level is essential.

But prevention increasingly requires what clinicians sometimes call N-of-1 care: treating each patient as their own data set, with an intervention plan tailored to their specific biology, behavior, circumstances, and goals.

Two patients with identical A1c levels may require entirely different approaches. One may need nutrition counseling. Another may need medication adjustment. A third may be dealing with untreated depression that is driving disordered eating. A fourth may need help accessing affordable groceries before any clinical intervention can work. Technology now makes it possible to identify those differences and personalize care in real time.

S.197 should be designed to enable that kind of personalization. If the program structures incentives rigidly, defines primary care too narrowly, or measures compliance through a single financial ratio, it may instead reinforce standardized pathways that are, by design, not optimized for the individual patient.

C. Rapidly Evolving Moment for Primary Care

The pace of change in primary care is accelerating rapidly. Advances in digital health, remote monitoring, data interoperability, and analytics are already reshaping how prevention is delivered—often outside the traditional office visit and increasingly between encounters. These capabilities are not speculative or distant; they are being deployed today, and they are changing expectations among patients, providers, and care teams.

At this moment of transition, policy design matters enormously. If S.197 is structured around legacy definitions, visit-based metrics, or rigid compliance frameworks, it risks locking in yesterday's model just as the system is gaining the tools to move beyond it. Conversely, if the bill preserves flexibility, modernizes definitions, and aligns incentives with outcomes rather than activity, it can help accelerate a transformation that is already underway rather than inadvertently constraining it.

V. Accountability Must Be Built Around Outcomes, Not Just Spending

A. The Limitation of a Percentage Target

MVP supports meaningful investment in primary care. The question is not whether to invest—it is what we are investing in, and how do we know it is working?

A spending percentage answers one question: How much are we spending? It does not answer the more important question: Are our investments ensuring people are healthier?

Consider what a percentage target actually measures in practice. If acute care costs rise — driven by new drugs, new procedures, or simply population aging—total medical spending rises with

it. The 15 percent benchmark rises too. Payers could increase real, absolute primary care investment and still fall short of the target because the denominator moved. Conversely, payers could appear compliant on paper while that spending is flowing largely into additional visit volume rather than into the prevention infrastructure that reduces long-term cost.

More fundamentally, tying reform to a percentage of total spending risks anchoring the system to continued cost growth. If the goal is genuine health improvement and cost containment, the accountability structure should say so directly.

B. A Framework for Outcome-Based Accountability

Instead of asking only whether 15 percent of spending is flowing to primary care, Vermont should ask what that investment is producing in how primary care practices operate and serve patients. Increased spending alone does not create access; capacity is created by how practices are structured, staffed, and supported.

Enhanced primary care spending should carry clear, practice-level expectations tied to expanded capacity, improved access, and stronger continuity of care. Absent those expectations, increased spending risks reinforcing existing constraints rather than relieving them.

Specific, measurable expectations of participating primary care practices could include:

- **Expanded capacity and access:** Demonstrated reductions in average wait times for new and established patients; expanded same-day or next-day appointment availability; increased after-hours, weekend, and virtual access.
- **Ability to absorb unmet demand:** Increased panel capacity, particularly for patients without an attributed primary care provider or with complex chronic needs.
- **Care team deployment:** Use of multidisciplinary care teams—such as nurses, behavioral health clinicians, care coordinators, community health workers, and pharmacists—to extend capacity beyond the physician visit and operate at the top of license.
- **Continuity and longitudinal engagement:** Improvements in continuity of care for high-need patients and reductions in the number of Vermonters without a consistent primary care relationship.
- **Between-visit infrastructure:** Demonstrated use of telehealth, remote monitoring, proactive outreach, and care coordination to support patients between visits—not solely during office encounters.
- **Interoperability, data liquidity, and advanced analytics:** Participation in interoperable, bidirectional data-sharing arrangements that enable timely exchange of screening results, clinical notes, care plans, and member-level information between practices and payers, and support the use of advanced analytics and AI-enabled tools to identify risk, prioritize outreach, support clinical decision-making, and enable proactive prevention between visits.

> *These expectations are not about prescribing clinical decisions or dictating care models. They are about ensuring that enhanced primary care investment translates into real, visible improvements in access, capacity, and continuity. Meeting these expectations should be a baseline condition of participation. How*

> *practices are ultimately rewarded should depend on whether these operational improvements translate into better health outcomes for patients.*

Many of these expectations—expanded access, proactive outreach, and between-visit engagement—exist precisely to address the last mile of care, where prevention succeeds or fails.

C. Moving from Activity to Outcomes: Aligning Incentives with Health Improvement

While practice-level expectations should be required as a condition of enhanced investment, payment reform should ultimately reward results, not activity. A core risk in S.197's current structure is that it may reward activity rather than improvement. Screening rates, documentation, and visit volume are process measures. They are not, by themselves, evidence that Vermonters are healthier.

A primary care payment reform program should distinguish clearly between inputs and outcomes. Screening a patient for diabetes is an input. Improving A1c control is an outcome. Documenting hypertension is an input. Achieving sustained blood pressure control is an outcome. Conducting a depression screening is an input. Reducing symptom severity and improving functional status is an outcome. Practice expectations establish the floor for participation. Outcomes should determine how success is rewarded.

If providers are paid primarily for performing activities—regardless of whether those activities translate into improved health—the system will predictably optimize for volume and compliance, not results. That is not a failure of providers; it is a function of incentive design.

To avoid this outcome, S.197 should explicitly require that enhanced primary care investment be tied to measurable improvement in health outcomes over time, not solely to the completion of specified activities or services. Providers should be incentivized—and rewarded—for producing demonstrable improvements in chronic disease control, preventive care effectiveness, avoidable utilization, and continuity of care.

Outcome-based accountability does not mean rigid, one-size-fits-all targets. It means establishing clear expectations that investment will produce results, while allowing flexibility in how practices achieve those results based on patient mix, community needs, and care models. When payment is aligned with outcomes, providers are empowered to invest in the tools that work—care coordination, behavioral health integration, remote monitoring, health coaching, and personalized interventions—rather than simply increasing visit volume.

Absent this alignment, Vermont risks increasing primary care spending without meaningfully changing the trajectory of chronic disease, access, or avoidable utilization. Investment without outcome accountability may satisfy a benchmark on paper, but it will not deliver the transformation patients expect.

VI. Structural Design Concerns: Equity, Market Stability, and Federal Alignment

A. The ERISA Exemption and Market Equity

S.197's spending requirements will apply to fully insured commercial health plans including MVP, Blue Cross Blue Shield of Vermont, and other regulated insurers. Self-insured employer-sponsored plans, which cover a substantial portion of Vermont's commercially insured workforce, are exempt from state insurance regulation under the federal Employee Retirement Income Security Act (ERISA) and will not be subject to the mandate.

This asymmetry creates a structural problem. If compliance obligations and their associated costs fall exclusively on the fully insured market, Vermont risks concentrating financial pressure on a shrinking segment of the commercial market while inadvertently accelerating the migration of employers into self-insured arrangements that fall outside the program's reach.

That dynamic does not strengthen Vermont's primary care system. It narrows the funding base while increasing the cost burden on those who remain in it. The Committee should actively engage with this equity concern and consider how the program's design—including its voluntary participation outreach to self-funded plans under subsection (f)—can be structured to encourage broader participation rather than creating an incentive for avoidance.

B. Vermont's Existing Federal Partnerships

Vermont is currently engaged in meaningful federal reform work through the Rural Health Transformation Program and the AHEAD Model—a multi-year, multi-payer initiative that includes both Medicare and Medicaid and is designed to modernize primary care payment across the state. These initiatives represent significant state-federal partnership and reflect Vermont's national leadership in health system transformation.

As S.197 advances, the Committee should carefully evaluate how the bill's design and implementation timeline align—or could come into conflict—with these existing federal commitments. Overlapping structures, inconsistent definitions, or conflicting financial incentives could create significant administrative burdens for plans and providers already participating in federal initiatives. Vermont should be building in one direction.

We encourage the Committee to require an explicit analysis of federal alignment and—if appropriate to move S.197 at all—to build adequate transition periods into the bill's timeline to accommodate coordination with CMS.

C. Commercial Market Stability

Vermont's own health reform materials acknowledge that the commercial insurance market is under significant financial pressure. Premiums have risen sharply, and insurers operating in Vermont's individual and small group markets have faced ongoing financial challenges. Layering a new mandatory premium allocation onto commercial carriers before broader market stabilization efforts are complete could weaken the very financing foundation on which sustained primary care investment depends.

Sustainable primary care investment requires a stable financing base. The Committee should consider whether the bill's timeline allows adequate runway for the market to stabilize and whether phased implementation—with clear milestones tied to market conditions—would reduce this risk.

VII. Preserving Innovation and the Plan-Practice Partnership

Today, MVP and other Vermont plans work in close collaboration with primary care practices to develop customized value-based arrangements—agreements that are tailored to the specific needs, patient populations, and capabilities of individual practices and communities. These arrangements allow us to invest in what works locally: in one community, that might mean enhanced care coordination for high-risk patients; in another, it might mean behavioral health integration or telehealth infrastructure.

A uniform state mandate risks converting those dynamic, locally-tailored partnerships into compliance exercises. When the primary question shifts from 'What is working for our patients?' to 'Are we at 15 percent?', the energy of the plan-practice relationship shifts with it.

Vermont's primary care landscape is not uniform. Any payment reform program should preserve enough flexibility that plan-practice innovation can continue alongside any benchmark—not be displaced by it.

VIII. Summary of Recommendations

MVP respectfully asks the Committee to consider the following design priorities as S.197 advances:

- **Modernize the definition of primary care** to reflect how health is actually delivered and improved today, including team-based care, telehealth, remote patient monitoring, behavioral health integration, community health workers, and non-claims care coordination infrastructure. Prescription drugs used for prevention and chronic disease management should also be captured, subject to appropriate guardrails.

- **Pair any primary care spending target with clear, practice-level expectations as a condition of participation**, including measurable improvements in access, capacity, and continuity of care. Enhanced investment should require participating practices to demonstrate expanded appointment availability, reduced wait times, increased ability to absorb unmet demand, effective deployment of multidisciplinary care teams, and meaningful engagement with patients between visits.

- **Distinguish clearly between participation expectations and performance rewards**, recognizing that meeting baseline operational expectations should establish eligibility for enhanced investment, while outcomes should determine how success is rewarded.

- **Require that primary care payment reform ultimately reward results, not activity**, by tying financial incentives to measurable improvement in health outcomes over time—including chronic disease control, preventive care effectiveness, continuity of care, and reductions in avoidable emergency department visits and hospitalizations—rather than to screening rates, documentation, or visit volume alone.

- **Address the ERISA exemption and market equity concerns** by designing the voluntary participation framework for self-funded plans in a way that encourages broad engagement and mitigates incentives for migration away from the fully insured market.

- **Ensure alignment with Vermont's existing federal reform initiatives**, including the AHEAD Model and the Rural Health Transformation Program, by requiring explicit coordination, consistent definitions, and appropriate transition timelines.

- **Preserve flexibility for plan-practice innovation**, allowing locally tailored value-based arrangements to continue alongside any benchmark framework, rather than being displaced by a state-run, uniform compliance model.

- **Consider phased implementation tied to market conditions**, recognizing the financial pressure on the commercial insurance market and the importance of a stable financing base for sustained primary care investment.

IX. Conclusion

Vermont has a genuine opportunity in front of it. The question S.197 ultimately poses is not whether to invest more in primary care. That question is largely settled. The question is what we want to pay for—and how we know whether it is working.

If Vermont defines primary care broadly enough to reflect where health is actually won and lost—in the sustained relationships, the technology-supported monitoring, the behavioral support, and the community resources that carry care from the clinic into daily life—this bill can accelerate real transformation.

If Vermont pairs investment with clear, measurable outcome expectations, it can hold the system accountable for something that matters: whether people are actually getting healthier.

If Vermont builds enough flexibility into the program to allow innovative plan-practice partnerships to continue, it can harness the energy and expertise that already exist in the Vermont health system rather than replacing them with a compliance framework.

The goal is not to spend 15 percent on primary care. The goal is to help Vermonters—wherever they live, whatever conditions they manage, however they access care—stay healthy, return to health when they are sick, and prevent their conditions from worsening over time. If payment design reflects that ambition, Vermont can lead.

MVP thanks the Committee for the opportunity to submit these comments and looks forward to continued engagement as the bill advances.