

1 TO THE HONORABLE SENATE:

2 The Committee on Health and Welfare to which was referred Senate Bill
3 No. 197 entitled “An act relating to establishing a primary care payment
4 reform program” respectfully reports that it has considered the same and
5 recommends 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

8 It is the intent of the General Assembly to invest in primary through
9 streamlined primary care payments that build on the Blueprint for Health and
10 will promote the public good by increasing access to primary care in order to
11 improve the health of Vermonters and reduce health care system costs.

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

13 Subchapter 1. Blueprint for Health

14 § 701. DEFINITIONS

15 As used in this chapter:

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

20 * * *

1 Agency's request, all information that the Director of the Blueprint deems
2 necessary to perform a comprehensive fiscal analysis of the total cost of care
3 within Vermont and to implement one or more payment models that address
4 health care capacity, volume, quality, and clinical outcomes.

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

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

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

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

20 (2) Consistent with recommendations of the Blueprint Executive
21 Committee, the Director of the Blueprint may recommend to the

1 ~~Commissioner of Vermont Health Access~~ Secretary of Human Services
2 changes to the payment amounts or to the payment reform methodologies
3 described in subdivision (1) of this subsection, including by providing for
4 enhanced payment to health care professional practices ~~that operate as a~~
5 ~~medical home~~, including medical homes and primary care naturopathic
6 ~~physicians'~~ practices; payment toward the shared costs for community health
7 teams; or other payment methodologies required by the Centers for Medicare
8 and Medicaid Services (CMS) for participation by Medicaid or Medicare. In
9 formulating recommendations, the Director shall strive to achieve or maintain
10 parity across payers and payment methodologies and to adjust payment
11 methodologies annually as needed to adequately support practices in
12 maintaining NCQA PCMH status or meeting other requirements for
13 participation in Blueprint programs.

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

20 (4) In the event that the Secretary of Human Services is denied
21 permission from the Centers for Medicare and Medicaid Services (CMS) to

1 include financial participation by Medicare, health insurers shall not be
2 required to cover the costs associated with individuals covered by Medicare.

3 (d) ~~An~~ A health insurer may appeal a decision to require a particular
4 payment methodology or payment amount to the ~~Commissioner of Vermont~~
5 ~~Health Access~~ Secretary of Human Services or designee, who shall provide a
6 hearing in accordance with 3 V.S.A. chapter 25. ~~An~~ A health insurer
7 aggrieved by the decision of the ~~Commissioner~~ Secretary or designee may
8 appeal to the Superior Court for the Washington District within 30 days after
9 the ~~Commissioner issues his or her~~ Secretary or designee issues a decision.

10 * * *

11 § 710. PRIMARY CARE SPENDING TARGETS

12 The Agency of Human Services shall establish a target for the amount of
13 per-person per-month spending on Vermont residents that should be for
14 primary care services and shall develop a transitional schedule that increases
15 that target over time. Targets may be adjusted to reflect payer-specific
16 differences, such as age and health status. The increased spending shall be
17 directed to the per-person per-month payments established in section 706(c) of
18 this chapter.

1 Sec. 3. BLUEPRINT PAYMENTS TO PRACTICES; PRIMARY CARE;
2 REPORT

3 On or before January 1, 2027, the Director of the Blueprint for Health, in
4 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 necessary to transition the Blueprint's per-
9 person per-month payments to primary care practices to include payment for
10 the routine primary care needs of attributed patients who are covered by
11 participating health plans. The report shall:

- 12 (1) define which services should be considered routine primary care;
13 (2) address any differences in methodology for different practice types;
14 (3) make recommendations regarding risk-adjustment and attribution
15 methodologies;
16 (4) describe the ways in which the methodology will balance capacity,
17 volume, quality, and outcomes;
18 (5) include mechanisms for ensuring that health plans make accurate
19 and appropriate payments to primary care practices in a timely manner;
20 (6) make recommendations regarding participation or quality
21 measurement requirements, or both;

1 (7) provide an analysis of including cost-sharing amounts for individuals
2 covered by participating health plans in the methodology, including the extent
3 to which such inclusion would be permissible for a high-deductible health plan
4 without losing its eligibility to be paired with a health savings account;

5 (8) provide an analysis of ways to incorporate a primary care spending
6 allocation target into the methodology; and

7 (9) provide an operational plan and a description of any additional
8 legislation needed in order to implement the methodology not later than
9 January 1, 2028.

10 Sec. 4. PRIMARY CARE SPENDING; AGENCY OF HUMAN SERVICES;
11 REPORT

12 On or before January 1, 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 definition of
19 primary care providers and services from the Advancing Healthcare Efficiency
20 through Accountable Design (AHEAD) Model or the definition of primary

1 care services used by the New England States Consortium Systems
2 Organization (NESCO).

3 Sec. 5. PRIMARY CARE SPENDING TARGETS; REPORT

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

12 Sec. 6. VERMONT CLINICIAN LANDSCAPE; SITE-NEUTRAL
13 REIMBURSEMENTS; REPORTS

14 On or before January 1, 2027, the Green Mountain Care Board shall report
15 to the House Committee on Health Care and the Senate Committee on Health
16 and Welfare with:

17 (1) an updated version of the Board's 2017 Vermont Clinician
18 Landscape Study report that reflects the current climate among practicing
19 clinicians in Vermont; and

20 (2) an updated version of the Board's previous reporting regarding site-
21 neutral reimbursements pursuant to 2015 Acts and Resolves No. 54, Sec. 23;

1 2016 Acts and Resolves No. 143, Sec. 5; and 2017 Acts and Resolves No. 85,
2 Sec. E.345.1, including the current state of reimbursement differentials based
3 on practice setting and ownership type, along with a description of any
4 significant efforts that have been implemented since 2017 toward achieving
5 site-neutral reimbursements.

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

7 On or before January 15, 2027, the Agency of Human Services, in
8 consultation with the Vermont Steering Committee for Comprehensive
9 Primary Health Care, the Blueprint for Health, the Vermont Association of
10 Hospitals and Health Systems, the Vermont Medical Society, **Bi-State**
11 **Primary Care Association,** and other interested stakeholders, shall report to
12 the House Committee on Health Care and the Senate Committee on Health and
13 Welfare with recommendations for ways to accelerate the appropriate
14 transition of patients from hospital care to care delivered in a community
15 setting, including ways to reduce the extent to which primary care services are
16 delivered to patients in an inpatient hospital setting following surgery or other
17 acute care, when care delivered by a primary care provider in the community
18 would be as or more effective and less costly. The recommendations shall
19 include opportunities to use community health teams through the Blueprint for
20 Health to coordinate patients' care transitions. The Agency shall incorporate

1 the recommendations into the Health Care Delivery Strategic Plan as
2 appropriate.

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

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

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

14 Sec. 7a. ~~SUNSET~~

15 ~~18 V.S.A. § 33 (medical students; primary care) is repealed on July 1, 2027.~~

16 [Deleted.]

17 Sec. 10. 8 V.S.A. § 4092(i) is amended to read:

18 (i)(1) On a periodic basis but not less than once per calendar year, each
19 health insurer shall notify all individuals covered under its health insurance
20 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. 11. 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 payment reform for primary care”
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18 (Committee vote: _____)

19 _____

20 Senator _____

21 FOR THE COMMITTEE