TO THE HONORABLE SENATE:

The Committee on Health and Welfare to which was referred Senate Bill No. 197 entitled "An act relating to establishing a primary care payment reform program" respectfully reports that it has considered the same and recommends that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. LEGISLATIVE INTENT

It is the intent of the General Assembly to invest in primary through streamlined primary care payments that build on the Blueprint for Health and 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.

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 PRACTICES

(a) As set forth in 8 V.S.A. § 4025, health insurance plans shall be consistent with the Blueprint for Health as determined by the Commissioner of Financial Regulation.

(b)(1) Health insurers shall participate in the Blueprint for Health as a condition of doing business in this State as provided for in this section and in 8 V.S.A. § 4025.

(2) In order to facilitate development of the sustainable payment models necessary for the Blueprint's success, health insurers shall submit to the Agency of Human Services at least quarterly, or more frequently upon the

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

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

(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.

* * *

§ 710. PRIMARY CARE SPENDING TARGETS

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 that target over time. Targets may be adjusted to reflect payer-specific differences, such as age and health status. The increased spending shall be directed to the per-person per-month payments established in section 706(c) of this chapter.

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

On or before January 1, 2027, the Director of the Blueprint for Health, in consultation with the Blueprint Executive Committee and the Vermont Steering Committee for Comprehensive Primary Health Care, shall report to the House Committee on Health Care and the Senate Committee on Health and Welfare regarding changes to the payment amounts or payment reform methodologies, or both, that are necessary to transition the Blueprint's per-person per-month payments to primary care practices to include payment for the routine primary care needs of attributed patients who are covered by participating health plans. The report shall:

(1) 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.

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

On or before January 1, 2027, the Agency of Human Services, in consultation with the Green Mountain Care Board, shall report to the House Committee on Health Care and the Senate Committee on Health and Welfare the baseline per-person per-month spending on primary care services for Vermont residents overall and by each health insurer, third-party administrator administering a health plan or providing administrative services only for a health plan, Medicaid, and Medicare. The Agency shall use the definition of primary care providers and services from the Advancing Healthcare Efficiency through Accountable Design (AHEAD) Model or the definition of primary

care services used by the New England States Consortium Systems Organization (NESCSO).

Sec. 5. PRIMARY CARE SPENDING TARGETS; REPORT

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 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. VERMONT CLINICIAN LANDSCAPE; SITE-NEUTRAL REIMBURSEMENTS; REPORTS

On or before January 1, 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 Hospitals and Health Systems, the Vermont Medical Society, and other interested stakeholders, shall report to the House Committee on Health Care and the Senate Committee on Health and Welfare with recommendations for ways to accelerate the appropriate transition of patients from hospital care to care delivered in a community setting, including ways to reduce the extent to which primary care services are delivered to patients in an inpatient hospital setting following surgery or other acute care, when care delivered by a primary care provider in the community would be as or more effective and less costly. The recommendations shall include opportunities to use community health teams through the Blueprint for Health to coordinate patients' care transitions.

The Agency shall incorporate the recommendations into the Health Care Delivery Strategic Plan as appropriate.

~~Sec. 6. ACCESS TO CLAIMS AND HOSPITAL DISCHARGE DATA; BILL BACK; REPORT~~

~~(a) The Green Mountain Care Board, in collaboration with the Vermont Program for Quality in Health Care (VPQHC), the Vermont Health Information Exchange Steering Committee, and the Office of the Health Care Advocate, shall consider the existing regulatory structures in place for access to information from the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) and the Vermont Uniform Hospital Discharge Data System (VUHDDS) and recommend ways to improve access to the information for quality improvement purposes while preserving appropriate protections for patient privacy.~~

~~(b) The Board, in consultation with VPQHC, shall also recommend any modifications to statute or current practice that are necessary to enable VPQHC's expenses incurred in maintaining the statewide quality assurance system in accordance with 18 V.S.A. § 9416 to be billed back to hospitals and health insurers pursuant to 18 V.S.A. § 9416(c).~~

~~(c) On or before January 15, 2027, the Board shall report its findings and recommendations under this section to the House Committee on Health Care and the Senate Committee on Health and Welfare.~~

Sec. 8. REGIONAL UNIVERSAL PRIMARY CARE PROGRAM; REPORT

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

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

Sec. 7a. ~~SUNSET~~

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

[Deleted.]

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

(i)**(1)** On a periodic basis but not less than once per calendar year, each health insurer shall notify all individuals covered under its health insurance plans of any changes in pharmaceutical coverage and provide access to the preferred drug list maintained by the health insurer or its pharmacy benefit manager.

(2) Not less than 60 days prior to removing a prescription drug from its formulary or from the formulary maintained by a pharmacy benefit manager its behalf, a health insurer shall notify all individuals covered under its health insurance plans who filled a prescription for that prescription drug within the previous 12-month period that coverage for the drug will be discontinued and of the date on which the coverage will end.

Sec. 11. EFFECTIVE DATE

This act shall take effect on passage.

and that after passage the title of the bill be amended to read: "An act relating to payment reform for primary care"

(Committee vote: _____)

_____

Senator _____

FOR THE COMMITTEE