S.197 – Revised language for Secs. 1–3

Sec. 1. LEGISLATIVE INTENT

It is the intent of the General Assembly to invest in primary care ~~by establishing a~~ **through** streamlined primary care payment**s** ~~system~~ 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: **(NEW)**

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.

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§ 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 beginning in 2027** ~~and adjusted annually for Medicaid and health insurers beginning in 2029, to the extent not prohibited by federal law and to the extent that funds for the adjustments are appropriated by the General Assembly, by a rate that is not less than the Medicare Economic Index rate of growth and that achieves or maintains parity among payers~~.

(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.

(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.

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§ 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 **(NEW)**

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. 3a. PRIMARY CARE SPENDING; AGENCY OF HUMAN SERVICES; REPORT **(NEW)**

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. 3b. PRIMARY CARE SPENDING TARGETS; REPORT **(NEW)**

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.