Testimony to House Health Care Committee 4/1/2026
Rick Dooley, PA-C

I'd like to thank this committee for allowing me to speak to you today regarding the primary care bill S. 197. My name is Rick Dooley, and I am a Family Medicine Physician Assistant at Thomas Chittenden Health Center in Williston, where I have worked for the past 27 years. I am also the clinical network director for HealthFirst, the independent practice association in Vermont, as well as an alternate on the Vermont Steering Committee for Comprehensive Primary Health Care. I've been involved in health care reform now for over 12 years, starting with the Vermont Health Care Innovation Project that was funded through the SIM grant in 2013, through the fits and starts of the organization that became OneCare Vermont, and now looking ahead (if you'll pardon the pun) to the AHEAD model and these legislative efforts on comprehensive primary health care. Through it all, I have continued to provide care for my panel of about 1500 patients at Thomas Chittenden.

I would like to tell you a little bit about our practice, for those of you who don't know us. We are a large independent primary care practice made up of 4 physicians and 8 Advanced Practice Providers (PA's and NP's) providing high quality primary care to patients from Chittenden, Franklin, Addison, Grand Isle, Washington and Lamoille Counties. We have a full time nutritionist/diabetic educator, a social work care coordinator, two clinical social workers providing counseling and two psychiatric nurse practitioners who provide psychiatric medication management. Several of these clinicians are from the Community Health Team, funded by the Vermont Blueprint for Health.

Chair Black requested that I speak to NCQA in my testimony today. As a requirement of participation in the Blueprint, practices must achieve the Patient Centered Medical Home (PCMH) certification from the National Committee for Quality Assurance, or NCQA. PCMH is a widely adopted, evidence-based model that transforms primary care into a team-based, patient-centered system. It focuses on improving quality of care, patient experience, and staff satisfaction while reducing overall health care costs through better coordination and increased access. While many practices were already functioning as medical homes, the process to become certified initially is rather arduous, and once completed, practices must recertify annually. Over the course of the year, each practice must undertake a number of quality improvement projects that span several domains, including preventive health, chronic condition management, access, resource allocation and care coordination. Practices work with a Blueprint facilitator throughout the year to collect and organize the data for submission. Unfortunately this recertification work

requires significant time and effort from both office staff and providers, simply to reaffirm that we are continuing to meet the standard of PCMH.

The Blueprint has been beneficial for many practices, including Thomas Chittenden. It provides a per-member-per-month payment to practices for attributed patients, as well as a dollar amount to be used for access to the Community Health Team. These resources have been integral in our ability to provide care, and the Blueprint's payer agnosticism is a model that should be replicated across medicine. As we expand our scope of what is considered Comprehensive Primary Care, there are many necessary patient resources that are simply not reimbursable in a fee-for-service system. The goal of the Blueprint was to provide ancillary staff and funding to help offset those unreimbursed costs, but that funding has been inadequate to date. With the exception of a small bump in 2019, the Blueprint PMPM has remained essentially unchanged since 2015. Likewise, the CHT funding allowance has remained unchanged since that same time, with the exception of the Expansion Pilot for Mental Health in 2023. As payments remain stagnant while costs increase, the Blueprint funding becomes less and less relevant, and practices become less and less able to retain their clinical staff.

What separates independent practices like Thomas Chittenden from our hospital owned or FQHC colleagues is our funding source. Hospitals get significantly higher commercial reimbursements than us for providing the same care, and also have the ability to shift funding within the organization, drawing from more profitable areas to supplement less profitable. FQHC's receive enhanced payments from Medicare and Medicaid, in addition to receiving grants from the federal government. Independent practices, however, are solely dependent on insurance reimbursement for revenue, along with a small fraction of assistance coming from the Blueprint. We face the same pressures as small businesses across the state – the astronomical rise in health insurance premiums, the lack of affordable housing and the shortage of workforce employees. In addition, because of our decreased reimbursement, we are often at a financial disadvantage in recruitment of any employee – clinician or staff – when competing with the hospital system. It is for these reasons that we think primary care payment is one of the most important pillars of health care payment reform, and crucial for our independent practices.

Thomas Chittenden was fortunate to be part of the Comprehensive Payment Reform (CPR) model for OneCare for the past 5 years. This model allowed us to receive a prospective per-member-per-month fee for our Medicare and Medicaid population, with additional payment based on quality, allowing us to focus on patient care rather than patient volume. In the OneCare capitated system, the incentive was to provide high quality care and reduce

emergency room visits through improved primary care access. The enhanced funding allowed us to add care coordination services. In addition to our regular Blueprint funding, the Community Health Team Expansion Pilot from the Blueprint allowed us to expand our mental health services and add a psychiatric nurse practitioner. These programs all focused on increasing primary care spending to offer enhanced programs, rather than just rewarding the number of people walking through the front door.

I have innumerable examples of patient outcomes that were positively affected by this enhanced payment model. One that I would like to share with you is a patient of mine, an older lady who I'll call Diana. Diana has had a number of medical issues over the years, including some underlying heart and lung disease, but is generally in reasonably good health for her advanced age. She lives in an assisted living facility, and that transition was difficult. Several years ago, she started going to the emergency room more regularly, for various complaints. It may have been breathing issues, or chest pain, or abdominal pain, or rib pain. Each ED visit typically resulted in labwork and often advanced imaging (CT's, MRI's), but somehow symptoms frequently seemed to resolve once she was evaluated. It became apparent that there was a significant psychosocial component that was driving many of these costly visits. Diana was identified as a patient who would benefit from intensive care coordination, as well as close follow up with me as her trusted primary care provider.

We initiated a schedule of visits with me on a monthly basis, even if she was feeling well. The assisted living staff noted that if she started getting anxious, she would calm down when told that she had an upcoming appointment at our office. Our care coordinator worked extensively with her housing staff to address her home situation and make it less anxiety-provoking. Our counseling staff worked with her to address her underlying trauma history, which had resulted in anxiety and mood disorder. In addition, my nurse and I reinforced a policy of getting Diana into the office for a same day visit whenever needed. The end result was remarkable. Her emergency room visits went from 1 to 2 times a month to maybe once every 4-6 months. She has not had a single inpatient admission. She is happier and healthier, and the health care spend is substantially less.

The services that allowed that wrap-around care of Diana – the care coordination, the counseling, the flexible scheduling – were only available because of the enhanced payment system we have been functioning under. Services like care coordination are generally not well reimbursed. A prospective per-member-per-month payment model allows practices to build and sustain these systems so that patients can get the care they need, when they need it, and at the most appropriate (and cost-effective) site.

The Holy Grail for years has been to find a way to fully and adequately fund the system so that every Vermonter has easy access to affordable and high quality primary care, resulting in improved health outcomes and reduced hospital costs. While there have been plenty of efforts in the past toward this goal, the reality is that primary care funding right now is unpredictable and inadequate. The payment system is fragmented and burdensome. The administrative burden on primary care providers is crushing. And through it all, health care costs have continued to climb while health insurance premiums skyrocket.

The concept of paying prospectively for primary care is not new. I worked Craig Jones at the inception of the Blueprint as he was establishing the PMPM model. I worked with Todd Moore at the start of OneCare on developing a blended PMPM that adequately accounted for patient risk. I worked with Tom Borys and the One Care team as we refined that model into the Comprehensive Payment Reform model for primary care. This work has been done. The problem is not that folks don't know how to create a PMPM system, or even how to figure out what that payment should be. The problem is that it has to be funded in a sustainable way across all payers. That has been and continues to be the challenge.

The system as it stands today is not sustainable. I am hopeful that this time around, we'll find a way forward that will result in a suitable, sustainable funding model to support a robust primary care system.

Thank you for your time and attention. I'd be happy to answer any questions you have.