S.197 An act relating to establishing a primary care payment reform program
1/29/2026

Good Morning Chairwoman Lyons, Committee Members, and Guests thank you for allowing me the opportunity to speak today. I have met some of you in the past, but as a reminder I am Anne Morris, a Family Physician in Milton, Vermont. I have worked with the UVM Family Medicine Residency Program for over a decade and, as of last May, I am the Associate Dean for Primary Care and the Vermont AHEC Network at the Larner College of Medicine. I am also a board member for Vermont Medical Society and Vermont Academy of Family Physicians and, as always, please consider the following words my own and not the direct opinions of my employers.

> Introductions aside, I'd like to start with some reflection on where we are today. As these reflections often go, it was 4:30 on a Friday afternoon, I had already been in clinic all day and worked through lunch. And my patient looked at me and said with tears in their eyes, "Why does everything have to be so hard?" We were talking about caring for their shoulder, one that had been injured after a fall. The pain was keeping them up at night and despite previous recommendations from us to "rest" and do some home exercises, they were continuously using their arm at their job in a local nursing home. I was recommending formal physical therapy to speed recovery and they said with a bit of anger, "It's just so expensive".
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> Another patient, came to see me for a preventative physical and asked me to "do everything that I need now and in the future" because she plans to go without insurance in 2026. Her work in preschool education, a job that requires a undergraduate degree in early childhood development, doesn't pay enough for her to afford the premium increase for insurance on Vermont's Health Care Exchange.
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> And, finally, several of my Medicare patients are coming to see me at "out-of-network" costs because their plans have all changed this year and their premiums are, in some cases, now higher than their monthly social security checks – but they desire to stay with the provider they've been with for years and who knows them best despite the cost.

I had a hard time composing my thoughts into what I want to say to you as a committee today. In my world, this feels like a high-stakes conversation, and I need to convince you that investing (really investing) in primary care is the right thing to do for our patients, the providers, and the healthcare system. It feels high stake because we are trying to please everyone while proposing that, to do this right, we need to invest MORE money into primary

care while trying to reduce the money that is going into health care as a whole. And, yet, I am going to try anyway.

We can all agree that investing in primary care reduces total health care dollars spent and improves the lives of people. By now you are all familiar with the statistic that for every $1 spent in primary care, it saves the system $13 dollars. It does this through relationship building and trust. Did you know that providers need to have close a 70% continuity rate with their patients in order to improve health outcomes. And, that the longer the continuity relationship lasts, the greater the impact on reducing resources spent on urgent care visits, emergency rooms and hospitalizations (a study published in Norway in 2022 actually showed that when the continuity relationship lasts >15yr, it reduces emergency care/hospitalizations by 25-30%).

This directly speaks to creating an environment that is easy to access for patients while being affordable and sustainable for providers. At AHEC, we review and update a roster of open positions within the state quarterly. As of Dec 2025, there were 79 open primary care positions in the State, and we have all seen the predictions on how this number is going to continue to rise. It is not easy to recruit and then retain providers in Vermont and for that Vermonters suffer with decreased access to care through longer wait times and the burden of having to travel farther for care.

There are many reasons that it is harder to recruit providers to rural places. It starts with having a smaller pool of people coming from these areas with interest in becoming primary care providers in the first place, it is worsened by not having enough clinical training in rural areas to increase provider confidence (and make them fall in love with the communities), and it is compounded by high educational debt and the fact that rural areas traditionally pay the lowest salaries in a field that already has significantly lower salaries compared to specialties colleagues.

Addressing these workforce development challenges takes a longitudinal approach that starts with introducing students to careers in health as early as middle school and continuing these exploratory opportunities all the way through undergraduate education. It continues in medical school and residency training through early and frequent exposure to health care in rural communities and culminates through a variety of programs to reduce educational debt burden that help to attract and then retain primary care providers in the communities. Some really great examples of this work are programs such as C-SHIP, Governor's Institute of Vermont Institute of Medicine, the upcoming Maple Mountain Consortium rural family medicine residency program, AHEC Medical Student Incentive Scholarship at the LCOM, and the Vermont Educational Loan Repayment Program for Health Care Providers. I would be happy to come back and expand on these.

So, once we get providers to Vermont, we have to work hard to create a system where they can afford to practice and where they feel that they are valued by the community and the systems within which they are providing care. This is the part of S.197 that becomes exciting to me. In this bill we are trying to talk about increasing total investment in primary care, we are talking about investing in primary care teams so that there we can meet individual patients where they are, help to make their diagnoses more manageable, and provide the short-term follow through that providers whose schedules are booking out 3-6m can't provide. In order to do this successfully, I would like to comment on a couple of things from the bill.

- The proposed primary care spend rate feels bold at 15%, and it would be if we were starting this rate in 2027. By waiting to enact this in 2029, we will again already be behind the proverbial eight ball and it will take years of data collection and negotiating to raise this rate.
- For true primary care reform to be able to reach all Vermonters, we need to have all payers and all practices participating.
- Primary Care is a team-based sport, we can't achieve value-based care and meet quality metrics alone. It is extremely important that we increase our investment in initiatives like the BluePrint Community Health Teams to allow practices to provide that integrated care in patient centered medical homes needed to keep people out of the ED and meet their short and long term health goals.
- Paying for services provided is difficult and comes in many forms such as fee-for-service and capitated models – we are going to see a mix of this in reality. It's the focus on a per member per month (PMPM) payments like we see with BluePrint and monthly payments like we saw through OneCare's Comprehensive Payment Program that will make a measurable difference to practices
- Finally, we need to acknowledge that regardless of practice type: FQHCs, independent practices, or hospital-owned – we are all seeing the same patients – with the same degree of illness, degree of risk, and social and societal needs.
    - All practices need the advantages of reducing administrative burden, including prior authorizations. A primary care provider in Middlebury ordering a CT scan has the same credentials and burdens as one providing care in Randolph.
    - All practices, regardless of type, also need access and investment in technology like ambient AI technology for documentation and resources to bring Point-of-care ultrasound to primary care practices.

In summary, I want to acknowledge that these concepts are complex and broad and yet, by tackling them, we have the opportunity to improve the health of all Vermonters and reduce the total cost of healthcare in Vermont in a meaningful way by making a bold, long-term investment in primary care that provides the right care at the right time in the right place for patients.

It gives practices financial stability while reducing administrative burdens and allows for innovation that meets the needs of individual communities.

It also creates an environment that not only attracts but retains providers in their practices by naming the value that their services provide to their patients and communities.

Thank you for your consideration.