To: Senate Health & Welfare Committee
From: Jessa Barnard, Executive Director
Date: January 22, 2026
RE: S. 197, Establishing a primary care payment reform program

The Vermont Medical Society is the largest physician membership organization in the state, representing over 3,100 physicians, physician assistants and medical students across all specialties and geographic locations. The mission of the Vermont Medical Society is to optimize the health of all Vermonters and the health care environment in which Vermont physicians and physician assistants practice medicine. **VMS along with our colleagues at the Vermont Academy of Family Physicians and American Academy of Pediatrics – Vermont Chapter, strongly support S. 197. Here is why:**

The Problem - Vermont's Healthcare System is in Critical Condition

$1=$13

For every dollar spent on primary care, there is a potential return of $13 in overall healthcare savings. (Commonwealth Fund)

This is because strong primary care leads to:

- **better health outcomes**
- **fewer emergency room visits and hospitalizations**
- **more effective management of chronic conditions**

Vermont only allocates **10 cents of every healthcare dollar** to primary care. (GMCB Report 2020)

- **Health Insurance Crisis**
  Skyrocketing premiums are making commercial health insurance increasingly unaffordable for individuals, families, and employers;
- **Limited Patient Access and High Costs**
  Lack of access to primary care pushes patients to urgent care, and emergency departments, resulting in fragmented care and overall higher healthcare costs;
- **Excessive Administrative Burden**
  Primary care clinicians spend roughly 50% of their time on documentation and desk work, diverting time from patient care and reducing practice satisfaction
- **Misaligned Incentives and Underinvestment**
  Reimbursement structures often favor procedures and interventions over primary care. In 2020, only 10.2% of total health care spending in Vermont was allocated to primary care;
- **Workforce Crisis**
  The primary care workforce shortage is increasing due to stagnant reimbursement, administrative burden and high burnout rates. Vermont will be short 370 PCPs by 2030.

The Solution - Increase Access & Funding to Primary Care

More investment in primary care will increase access to affordable healthcare for all Vermonters.

Primary Care Investment Target

- **Reallocate VT's Health Care Dollars to Primary Care:** Increase the percentage of health care spending to meet a primary care investment target of 15% of total health care spending by January 1, 2029.

Primary Care Payment Reform

- **Pay PCPs to deliver care:** Invest primary care spending in a voluntary payment reform program with global payments funded by commercial premiums and, if permitted, Medicare and Medicaid funds.
- **No out-of-pocket costs for patients**

Primary Care Workforce

- **Primary Care Scholarship and Loan Repayment:** Invest in primary care incentive scholarship and loan repayment for medical students who commit to practicing primary care in Vermont

We would offer one additional guiding principle that we have brought to this work: Create a framework with necessary targets and guardrails but leave as much detailed development as possible to the Vermont Steering Committee for Comprehensive Primary Health Care along with the implementing agency. Too often reform is done "to" primary care practices and not "with" primary care practices and practitioners – we suggest it is critically important to give time and opportunity for the primary care steering committee to help develop the details. (The Vermont Steering Committee for Comprehensive Primary Health Care was created in Act 68 of 2025 and is charged with informing "the work of State government, including the Blueprint for Health and the Office of Health Care Reform in the Agency of Human Services, as it relates to access to, delivery of, and payment for primary care services in Vermont.")

There are some specific changes we would recommend to the bill language based on recent conversations with other stakeholders:

- Section 2(a)(1) and throughout - Change the entity charged with implementing the primary care payment reform program from DVHA to the Agency of Human Services – while DVHA will play a critical role in development of the program and has a history of successfully developing and implementing alternative payments, they traditionally operate as their own payer. AHS also houses the Blueprint for Health which is a successful multipayer model of strengthening primary care in Vermont and may be the more appropriate program to lead the work – charging AHS with this work provides flexibility to the agency to house it where it is most appropriate.
- Section 2(a)(2) & 3(a) - Voluntary vs mandatory participation – you will likely hear more from practitioners and practices, but not all payment methodologies work for all practices depending on the services they offer, their payer mix and more. We do not support mandating participation before practices know if the model will indeed make them more sustainable. Ideally the program itself will be the "carrot" and all practice will want to participate.
- Section 2(b) – Recommend removing "reducing" Blueprint for Health requirements
- Section 2(b) – Consider adding access requirements (see H. 680)
- Section 2(d) & 2(f) – We encourage the Committee to consider how to fairly spread the payments for primary care across all payers – we recommend reviewing the Act 51 report of 2023 discussing how using the health care claims tax would simplify the contribution process for commercial insurers to the Blueprint program, ensure all insurers are contributing equitably to the Blueprint initiatives, and allow payments to automatically adjust for inflation as health claims adjust for inflation. This same methodology could apply to the primary care payment reform program.
- Section 2(g) – Consider language that more explicitly requires all payers to meet the spend target (see H. 680).
- Section 5 – We are unclear of the intent of the focus of the report on primary care services "delivered to patients in an inpatient hospital setting following surgery or other acute care" rather than more broadly looking at primary care type services offered in a hospital setting.
- Section 6 – This is not VMS' area of expertise but VMS understands that VPQ is already funded this way
- Section 7 – Support further study of this topic, but unsure of the feasibility of a multistate program given state-based insurance regulation.

Thank you very much for your focus on primary care and taking up S. 197. We look forward to working with you closely after you hear from additional experts and witnesses.