BlueCross BlueShield of Vermont

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Chair Lyons and Members of the Committee,

Thank you for the opportunity to provide our thoughts and optimism regarding S.197, a bill relating to Primary Care Reform. As we mentioned in testimony, we are hopeful that a modernized blueprint will move us towards a single model that more effectively achieves the goals and objectives of quality, affordability, and accessibility.

I have added a one-pager that highlights our efforts to produce these objectives.

As requested, here are a few thoughts from our team regarding what we would like to see added to the bill to ensure that these goals and objectives are met in the planning and implementation process.

Generally, we could support:

- Multi-payer simplification to reduce administrative burden on practices.
- A predictable and transparent PMPM structure
- Clear attribution methodology across payers
- Robust and transparent risk adjustment methodology (see below)

Requests:

- Explicit **cost-neutrality** guardrails so increased primary care PMPMs are funded through reallocation from specialty and hospital spending rather than increasing total premiums. This is the most critical element from a BCSVT premium affordability perspective—if we are going to pay $X more to PCPs, that should not increase our premiums.
- Clear risk adjustment standards embedded in statute or rule. Payment amounts and statewide spending targets should be **risk-adjusted by payer to reflect differences in age, acuity, and social complexity**. Without robust risk adjustment and explicit cost neutrality, commercial premium dollars could be required to finance (aka subsidize) primary care capacity calibrated to Medicaid member utilization.
- Defined and limited scope of “Blueprint initiatives” eligible for shared cost contributions
- Defined data submission requirements with specified datasets, governance, and confidentiality protections, including specific transparency requirements for Community Health Teams.
- Flexibility for payer-specific design elements above a common core framework, like what we are planning for 2027
- Cost growth tied to measurable outcomes (access, avoidable ED reduction, chronic disease control, cost trend moderation), not solely to Medicare Economic Index inflation as is stated in the bill

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We have attached a one-pager that outlines high level overview of our two internal quality programs (ECPC and VBIC). While all three programs, Blueprint, VBIC and ECPC, center on strengthening primary care and improving measurable quality, they are designed to achieve different system objectives.

- Blueprint functions as a statewide transformation model aligned with public health and Medicaid priorities, emphasizing foundational preventive care across the lifespan.
- ECPC serves as BCBSVT's integrated value platform, tying quality performance to total cost of care and risk accuracy to support financial sustainability.
- VBIC complements this by targeting specific utilization and site-of-care behaviors that directly influence commercial premium trend.

A full quality metric grid is attached, here is a summary:

Program	**# measures in 2025**	**Examples that show the program's focus**
Blueprint for Health (QPBPM)	4	Child & adolescent well-care visits; developmental screening (first 3 years); diabetes glycemic status assessment; hypertension control
BCBSVT VBIC	9	Avoidable ER use; colorectal cancer screening; diabetes HbA1c control; hypertension control; adolescent PHQ screening; plus explicit affordability levers (use lower-cost labs, lower-cost MRI/CT alternatives, formulary compliance)
BCBSVT ECPC	11	Adult immunization; breast + colorectal cancer screening; asthma med ratio; kidney health evaluation in diabetes; SUD initiation/engagement; antibiotic utilization for respiratory conditions; Total Cost of Care; plus risk adjustment-oriented items (HCC gap closure; diabetes glycemic status captured via CPT/claims)

Together, the programs reflect distinct funding structures, accountability models, and time horizons rather than duplication.